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ABSTRACT

A major goal of the project was to secure improved treatment resources for alcoholics and their families within family service agencies. The project sought changes in the following areas: (1) attitude change, (2) information transfer, (3) increase in effectiveness, and (4) a more open admission policy. After two training periods, a similar amount of positive attitude change was generated in each of the training groups. The pattern of change on a number of measures seemed directly related to the practice of the two groups of trainees. Results also indicate that positive attitude change occurred among staff members who did not participate in the program. However, this change was reflected in their practice measures only in a few instances. Individual, group and agency characteristics may be useful in explaining certain differences in direction and magnitude of change; however, the major outcome--an intervention was introduced and a desired change occurred after this intervention--continues to stand. There are indications that over time the change on some significant variables begins to taper off and the trainees' awareness of the gains they made in training increases. It is suggested that additional input is required to maintain change and sustain momentum created by the project. (Author)

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ALCOHOLISM: AN EVALUATION
OF INTERVENTION STRATEGY
IN FAMILY AGENCIES

Herbert J. Hoffman, Ph. D.
and
Ludmila W. Hoffman, M. A.

United Community Planning Corporation (formerly United Community Services of Metropolitan Boston) is a nonprofit citizen-led human services planning and research organization.

As the official planning partner of the United Way of Massachusetts Bay from which it receives its primary financial support, UCPC works with a wide variety of persons, community and minority groups, and public and private organizations toward a common goal: the overall improvement of human services policies and delivery systems.

FINAL REPORT

ALCOHOLISM: AN EVALUATION OF INTERVENTION STRATEGY IN FAMILY AGENCIES

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July 1974

PREFACE

As is often the case for many demonstration and training projects, the genesis of the work described in this report goes back many years - 1968 to be specific. I had a long-standing professional interest in alcoholism and had concluded that to significantly affect the typical course followed by many alcoholics, the non-specialized alcoholism caregivers had to be involved. The internist and general practitioner, the clergy, the rehabilitation counselor, the caseworker, and other professionals find themselves in frequent contact with the alcoholic and his or her family. It is often not skill which they lack but comfort in their role, and some help in clarifying the function of alcohol in our society and the attitudes toward it. As the Executive Vice President of a large metropolitan voluntary health and welfare planning council (I assumed the post in late 1967), I was then and remain in regular contact with a substantial segment of the voluntary human services system. I tested out my ideas about the need to involve social workers, whose case load included alcoholics and their families, with the executives of several family services agencies. They liked it so then data was collected on their caseload for several weeks and it was determined that 10-12 percent of their clients were indeed alcoholics or spouses of alcoholics. I then contacted the National Center on Alcoholism (now the National Institute of Alcohol Abuse and Alcoholism) and they too were interested. A grant proposal was written and eventually approved but for training, not for research as was originally proposed. Since funds were short, we found ourselves in the position of

being approved but not supported. When funds did become available two years later, they were at an amount equal to only half that originally requested, less inflation.

Despite this disappointment, the project went ahead at the reduced level. The training team was hired on a contract basis as planned. The evaluation and management team also was hired directly as planned. As principal investigator, I participated regularly in all of the project's policy and programmatic discussions, making ultimate decisions only if consensus was not achieved. The details of both the training and evaluation were assigned as above. Similarly, the following report is that of the research team, Herbert and Mila Hoffman. I made no substantive changes in my editing of it. I feel that they did an outstanding job and that, as a training evaluation report, it is of a superior level.

This is not to say that all participants in the project were always in agreement. The structure had some built-in tension potential and at times it surfaced. In particular, the training group was not always organized to facilitate effective monitoring and evaluation, and countless meetings failed to fully correct this problem. Yet, this permitted maximum critical freedom, an advantage seldom available. It is true that if the trainers had also been hired as staff of the project, rather than being contracted, that communication might have been facilitated and organization and schedules more faithfully followed. However, then we would have created a fundamental conflict of interest. How do you evaluate yourself? Thus, the existential choice in such experiments - control and conflict of interest, or no control and no conflict of interest. Looking back, I would have made the same

choice. Dr. Hoffman would have done it differently as he will tell you later in the report.

In an experiment involving the participants of seven independent organizations - NIAA, Family Service Association of Greater Boston, Cambridge Family and Children's Service, Family Counseling and Guidance Center, Family Counseling Services, Inc. (Region West), the Boston Family Institute and the then United Community Services of Metropolitan Boston (now United Community Planning Corporation) some complications are inevitable. In this case, they were all surmountable. I am most appreciative to all who participated. Without their full and complete cooperation we could not have successfully completed this experiment in training social workers employed by family agencies.

Harold W. Demone, Jr., Ph.D.
Executive Vice President
United Community Planning
Corporation
and Principal Investigator for

Alcoholism: An Evaluation of
Intervention Strategy in
Family Agencies

December 13, 1974

INTRODUCTION

The Task Force on Alcohol and Health reported in 1971 (First Special Report on Alcohol and Health, 1971) that alcohol is the most abused drug in the United States and that the dimensions of the alcohol problem continue to increase. Evidence gathered in the three years since this report was issued continues to emphasize the findings of the Task Force. Thus, a 1974 NIAAA draft working paper (From Program to Person, 1974) saw fit to reiterate the observations of the 1971 Task Force report:

> "Alcohol is the most over used drug in the United States with nine million alcoholic Americans -- seven percent of the adult population; alcohol is related to half the traffic fatalities and over forty percent of all non-traffic arrests; alcohol use and alcohol drain the economy of an estimated $15 billion a year; alcoholism is at epidemic level among American Indians, at least twice the national average, with rates as high as 25 to 50 percent on some reservations (p. 2)."

Leaders in the field of alcoholism estimate that during the next decade even the most vigorous program proposals addressing the problem of alcoholism will not begin to close the gap between needs and resources. NIAAA (From Program to Person, 1974) estimates that "probably fewer than 10 percent of the nation's alcoholic people are receiving the treatment they need (p. 5)." Currently, the demand for alcohol treatment services

already exceeds the capacities of available specialized facilities.[1] This is due in part to the increased numbers of alcoholic clients and, at least partially, it is due to the "revolving door" phenomenon. That is, specialized facilities tend to concentrate their treatment efforts on the alleviation of the presenting or obvious symptoms of alcoholism, while the broader social aspects of the alcoholic's being are often set aside and/or ignored. This view is emphasized in From Program to Person (1974).

> "...it is not sufficient to deal with one person alone. His problems do not exist in isolation. They affect his associates, family, and community, and they in turn impinge upon him in important ways. Any effort to rectify one person's pain without taking into account those who are around him is likely to be ineffectual because they, too, are worthy of support, and respond up to their best capacities and qualities only when they are stimulated to do so (p. 34)."

Returning the sobered and/or rehabilitated alcohol abuser to his family, job, community or other social system without having made an attempt to change those factors within the broader social structure that contribute to the alcoholic persons' problems, frequently means returning the client to situations which promote regression, relapse or renewed alcohol abuse behavior.

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1. Specialized facilities in this context refers to facilities which are specifically geared to treatment of alcohol symptomology and complications thereof, e.g., hospitals for alcohol abusers, detoxification centers, alcoholism clinics.

Frequently the narrowed concentration of specialized facilities is due to their lack of resources necessary for the treatment of the alcoholic individual as an integral part of a larger social system; other times it is due to exclusive adoption of treatment models specifically designed for and functional with one type of alcohol abuser, e.g., homeless alcoholic.

Examining the different types of facilities and their success in treatment of alcoholics, Pattison (1973) concluded that no one facility can provide a program that will meet the needs of all alcoholic sub-populations. In the planning and implementation of comprehensive community alcoholism programs there is a need for multiple treatment approaches which "should be construed as complimentary facilities serving particular population needs (p. 227)." Thus, during the most recent years, an impetus has been created to stimulate and coordinate a wide range of treatment facilities serving alcoholic persons and their families. Among many of these resources, community based generic facilities, such as family service agencies, appear especially well suited to promote treatment approaches emphasizing ecologically evolved supports.[2.]

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2. Generic facilities in this context refers to those facilities that have no specialized concentration on any one problemed population and/or symptomology, e.g., general hospitals, family service agencies. Generic agencies therefore treat a broad spectrum of problems or disfunctions.

They are geared not only to alleviation of a presenting problem, but to maintaining the more functional behaviors by simultaneous treatment of and consultation with environmental factors, e.g., spouses, parents, friends, which caused and/or supported the disabling behavior. In this manner it is believed that the family service agencies have the potential for influencing the social system of the alcoholic in such way that it no longer supports his/her abuse of alcohol.

The focus on family agencies' treatment of alcohol related problems from an ecological point of view was supported by T. Plaut (1967) in "Alcoholism: A Report to the Nation", as he pointed out that the programs of family agencies such as casework and family counseling seem to be well suited to alcohol rehabilitation. M. Bailey (1973) also supported this view as she observed that, "family agencies are more likely to think in terms of the total family, including the child and interaction among members (p. 25)."

Other authors dealing with treatment of alcoholism have supported the view that some of the most functional treatment modalities for alcohol problemed persons, such as casework, group therapy and family therapy, are most easily adaptable to and frequently used in family agency settings. Fox (1969), endorsing group therapy as one of the most successful techniques in the treatment of alcoholism, felt that the results of this therapy were best used in conjunction with aids such as

family treatment. Langsley, Pittman, Wachotca and Flomenhaft (1968) in evaluating family crisis therapy 6 months after termination concluded that for some alcoholic patients family crisis therapy could be as effective as hospitalization. Williams, Lewer and Bowers (1969), in their evaluation of short term family therapy aimed at exposing the cause(s) of alcoholism as well as alleviating the symptoms for alcoholics, concluded that family therapy is not only a workable arrangement for treatment of drinking behavior, but that it also contributes to the patient's adjustment in areas of employment and AA attendance.[3] Strach and Dutton undated found they achieved superior results in treatment of alcoholic persons when the spouse was involved in the treatment. Boswell and Wright (1973), in discussing a family intervention technique in the treatment of alcoholism point out that, "The need to treat the entire family, or system, when one individual is having symptoms, is essential (p. 2)."

It appears evident, therefore, that to a large extent the problem of alcohol abuse is influenced by the behavior of certain key persons living close to the one with the drinking problem, especially in family situations.

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3. Al-Anon, an outgrowth of AA, was founded in the recognition that alcoholism is a family disease requiring the involvement of the entire family for successful treatment.

Many alcohol abusers, especially in the early stages of their abuse, turn to generic agencies for assistance using physical, social and emotional problems as their guise for admission. Meeks (1970) estimated that in 15-20% of the applications to family service agencies, a drinking problem was involved. The applicant will typically be a non-alcoholic wife who views her immediate problem as physical abuse, debts, fear of the family breaking up or concern about children. Data collected during the course of the project reported herein indicated that 44% of clients in family service agencies, who were identified by caseworkers at some point in treatment as having alcohol abuse problems, originally complained of marital problems; among the remaining 56% in this category, 28% of the clients originally complained of difficulties with their children or intra-psychic problems; only 9% of the clients identified alcohol as the direct cause of their problems.

In view of these data, it would appear that family agencies might not only be well suited to address problems associated with alcohol abuse, but that they are uniquely suited to intervene in the problems of alcoholism at early stages when the family, though in stress, is still intact. In this way family service agencies have the potential to prevent serious family disintegration.

The family agencies' direct involvement in a service to alcohol related clientele, however, has been at least partially blocked by the prevailing negative attitudes held by staff members toward alcohol abusers and alcoholics, and the experience of inadequacy in training and skill on the part of professional staff members who attempt to treat these problems. A recent NIAAA working paper (From Program to Person, 1974) indicates both the awareness of the resource and its relative unavailability: "Family services for example would seem to be a logical source of help for most Americans, but that kind of agency has viewed family problems caused by alcohol to be the province of the physicians or Alcoholics Anonymous (p. 29)." Bailey (1970) points out that caseworkers, having been generally educated in institutions which overlooked the subject of alcoholism in their curricula, were graduated knowing relatively little about this disorder. They were further handicapped, Bailey continues, by the culturally based attitudes which were never subjected to critical examination. Plaut (1967) describes these attitudes as having been handed down from generation to generation with their roots deep in the concepts of self-control, will power, work and effort as man's natural state.

Without exposure to specialized course work on alcohol abuse and alcoholism, many students of social work are left

with adverse preconceptions, rooted in the cultural factors mentioned above. Data substantiating these conditions, as well as providing information regarding numbers and types of problem drinking cases carried, were gathered in a survey of caseworkers in five family agencies conducted by United Community Services of Metropolitan Boston (UCS) in 1969.

Caseload questionnaires were returned by 99 (82.5%) of the caseworkers employed in the surveyed agencies. These caseworkers reported that they were handling in all 2,205 cases. Of this total caseload, the caseworkers reported 321 cases (14.6%) in which drinking was a problem.

The "drinking cases" broke down as follows:

(a) In 105 cases (32.7%) the drinker was the primary client. This represented 4.8% of the 2,205 total case load.

(b) In 201 cases (65.7%) a member of the family other than the drinker was the primary client. This represented 9.6% of the total caseload.

(c) In 98 cases (30.5%) drinking was reported to be a major problem. This represented 4.4% of the total caseload.

Twelve of the 99 responding caseworkers (12%) stated that they had some kind of special training to help them in handling the client with an alcohol problem. The training described by the caseworkers consisted of previous clinical experience in an alcohol clinic, special seminars, lectures, attendance at special training institutes, and research in alcohol problems.

Sixty-one of the 99 caseworkers (62%) said they would have liked to have special training made available to them. The training considered to be the most useful by these workers would include:

(a) Improved and up-to-date knowledge of community resources and referral techniques.

(b) A better understanding of the medical aspects of alcoholism.

(c) Case studies and seminars.

(d) Psychiatric consultation on cases.

(e) Current findings of the "experts" in the research studies.

(f) Medical and legal aspects of the alcohol problem.

(g) Exposure to proven helping techniques.

Problems in the treatment of the alcoholic most often mentioned by the respondents were:

(a) The denial by the drinker and his family that an alcohol problem existed.

(b) A family environment that encourages the drinker to continue in his abuse of alcohol.

(c) A low tolerance on the part of the caseworker for the problems involved in alcoholism.

On the basis of these findings it was postulated that Greater Boston family agencies, in spite of their potential, had not become major resources in the treatment or rehabilitation of alcoholic persons. This situation appeared to result

from a sense shared by caseworkers, supervisors and administrators that they were inadequately prepared to treat the client with an alcohol problem.

The current project was designed and carried out in an effort to remedy these conditions.

Thus, a major goal of the project was to secure improved treatment resources for alcoholics and their families within family service agencies.

It was expected that the family agency staffs' attitudes and knowledge about alcohol and alcoholism would be constructively influenced by means of a group education approach and specialized skill training.

More specifically, the aims of the project's major intervention introduced by means of the training program were:

Attitude change.

To facilitate a more positive attitude toward the alcoholic, his/her family, and toward prognosis and treatment of this clientele. Furthermore, the training program was designed to instill confidence in the caseworker regarding his/her professional ability to deal effectively with the alcoholic in the context of his/her family.

Information Transfer.

To share basic facts about alcoholism, its treatment, and the community resources available to the alcoholic.

Increase in Effectiveness.

To actualize a more effective treatment of the alcoholic and his family within the agencies.

More Open Admission Policy.

To facilitate delivery of services to alcoholics and their families more frequently and to engage in therapy more successfully.

It was believed that in accomplishing these aims, the alcohol related clients treated at the agencies would be benefited, that the agencies' policies would be modified to be more receptive to the alcoholic client, and that the agencies' would increase the quantity of services delivered to the alcohol problemed population.

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PART I

PROJECT DESCRIPTION
and
IMPLEMENTATION

Chapter 1.

PARTICIPATING AGENCIES

The four family agencies involved in this project present themselves to the public in a very similar manner. Their principal services are usually described as counseling or casework and are available to families or individuals who suffer from a broad range of difficulties in daily living. A partial listing of the problem areas in which these agencies are able to deal with expertise includes marriage, pre-marriage, parent-child relationships, other inter-personal relations, adolescence, work adjustment, money management and unwed parenthood.

Each agency serves a geographic area which varies from a single city of approximately 100,000 to loosely defined areas with populations in excess of 1,000,000 people. A number of the family agencies' branch offices serve overlapping population areas. In no instance does any agency have a true exclusivity in a manner similar to community mental health centers where eligibility for and services in a particular center are based on residence in the catchment area.

The four agencies deliver direct services from 16 separate locations. Two agencies operate in six (6) locations each, one agency has three (3) and the agency serving a single city has one location. The two largest agencies are located less than a

mile apart in the heart of downtown Boston. In one community branch offices are operated a few doors apart from each other in the same office building.

Three of the four are member agencies of the Family Service Association of America, the accrediting, standard setting federation for more than 300 non-profit, voluntary, family social service and counseling agencies in the United States and Canada.

In an effort to provide a context and a backdrop for understanding the agency environments in which the project took place, each agency is described in outline form:

Family Counseling & Guidance Centers, Inc. (FC&G)

Locations: Main office in downtown Boston; branch offices, Quincy, Framingham, and Danvers.

No restricted catchment area. 90% of clients reside in the United Community Services of Metropolitan Boston (UCS) area (population of approximately 2.5 million).

Approximately 35 caseworkers on staff. UCS most recent allocation represents approximately 24% of operating budget. Operating budget (1972): $741,650.

Family Counseling Service, Inc. (Region West)

Locations: Main office in Newton; branch offices in Brookline, Natick, Waltham, Wayland and Wellesley.

Services residents of 12 cities and towns. 95% of clients reside in UCS area. Approximately 16 caseworkers of staff. UCS most recent allocation represents approximately 61% of operating budget. Operating budget (1972): $283,248.

Family Counseling Service of Cambridge (Camb)

Locations: Cambridge.

Services residents of Cambridge, population 100,000. Approximately 90% of clients reside in UCS area. Approximately 8 caseworkers on staff. UCS most recent allocation represents approximately 35% of operating budget. Operating budget (1972): $181,835.

Family Service Association of Greater Boston, (FSA)

Locations: Main office in downtown Boston; branches in Malden, Needham, Somerville, and Quincy.

No restricted catchment area. 99% of clients reside in UCS area. Approximately 63 caseworkers on staff. UCS most recent allocation represents 29% of operating budget. Operating budget (1972): $1,709,523.

During the period in which this project existed, all of the participating family agencies were experiencing the pressure created by high demand for services and reduction in financial resources. Contributing significantly to the financial plight were the rising rate of inflation, rising wages and the failure

of fund raising (Massachusetts Bay United Fund) to keep pace. Consequently, there were no substantial changes in the participating agencies' staffing patterns, even though demand for services continued at a high level. The number of caseworkers involved in the delivery of direct services remained stable during the life of this project, although there were minor fluctuations within the staff's of individual agencies.

Two of the four agencies did, however, undergo important changes which had both program and organizational implications.

FSA During the second year of the project, three top level personnel retired, i.e., Executive Director, Director and Assistant Director of Professional Services. The agency implemented an advocacy capability which had been in the discussion/planning stage for a number of years.

Camb As a result of federal cutbacks, the agency lost approximately half of its staff midway through the project period. New sources of grant and contract funding have since been acquired and the casework staff has been gradually increased.

The agency completed a merger in mid 1973 with the Avon Home, a Cambridge based organization providing foster care and adoption services, and has since become the Cambridge Family and Children's Service.

The four agencies, while sharing important similarities, such as the manner of public presentation, the type of services offered and the dominant discipline (social casework), in some ways were also different. The differences, however, e.g., more or less freedom allowed in caseworker's therapy style, more or less staff concentration in the inner city, did not appear to be reflected in significant differences in measured variables associated with the distribution of alcohol related cases and levels of workers attitudes toward alcohol and alcoholism.

One agency warrants special mention in considering the differences, i.e., Cambridge Family and Children's Service differed substantially in structure from the three other participating agencies in that it served only one community, had no branch offices, approximately 80% of its casework staff were employed on grants and contracts, and had fewer than 10 caseworkers on staff. In addition, no staff from this agency participated in the second round of training.

Chapter 2.

DESIGN

This project was intended to intervene in a generic care-giving system for the purpose of increasing the responsiveness to and the effectiveness of working with alcohol-problemed families. It was expected that the intervention would have an impact on line-workers, supervisory personnel, agency executives and agency policy. An evaluation design was developed to measure changes in areas considered pertinent for demonstrating the impact of the interventions introduced.

1. Intervention

The evaluation process was determined by:

(a) The nature of the population to whom the interventions were introduced.

The total population of caseworkers in four family agencies were potentially accessible for the purpose of data collection.

(b) The type of intervention introduced.

The major intervention consisted of two rounds of training program, scheduled seven months apart, for a self-selected sub-population of caseworkers.

(c) The time period involved.

Data was collected over a two year period.

Thus, the project was designed to allow repeated measurements on a defined, circumscribed population.

2. Repeated Measurements

The project design was keyed to the training program as the major instrument of intervention. The intervals chosen for repeated measurement, as well as the definitions of sub-groupings within the caseworker populations, were determined by the schedule for training and whether or not a worker participated in the training program. The three basic time periods are evident:

(a) Time 1 (t.1).

Pre-intervention - before any training has occurred; first administration of an attitude questionnaire and of caseload questionnaire.

(b) Time 2 (t.2).

During intervention -- after completion of first round of training; second administration of attitude and caseload questionnaires.

(c) Time 3 (t.3).

Post intervention -- after completion of second round of training; third administration of attitude and caseload questionnaires.

3. Population Groupings

Three basic staff groupings were evident:

(a) All caseworkers

(b) Trainees I[1]

(c) Trainees II[2]

The design of the project allowed for identification of additional more refined sub-populations for data analyses:

(a) All caseworkers (CW) minus caseworkers who participated in the first round of training (Tr. I), i.e., CW-I.

(b) All caseworkers (CW) minus caseworkers who participated in the first round of training (Tr. I) and caseworkers who participated in the second round of training (Tr.II), i.e., CW-(I&II).

(c) All caseworkers who completed and returned the A-0 questionnaires at all three times of data collection.

(d) Trainees I who completed and returned A-0 questionnaires at all three times of data collection.

(e) Trainees II who completed and returned A-0 questionnaires at all three times of data collection.

---

1. Trainees I - All caseworkers who participated in the first training program, January - May 1972.

2. Trainees II - All caseworkers who participated in the second training program, October 1972 - March 1973.

4. Control Procedures

Comparison between each group of trainees and the control group provided a measurement of the longitudinal effect of the training program. Those caseworkers not participating in the training program served as a control group for assessing change in each group of trainees.

The use of repeatdd measures on the same respondents introduced a further source of control in which each worker and each population or sub-population of workers served as his/her/its own control.

5. Areas of Evaluation

On the basis of the goals of this project four major areas of evaluation were selected:

(a) Change in Attitude

The training program was designed to facilitate a more positive attitude toward the alcoholic and his or her family and toward prognosis and treatment of this clientele. Furthermore, the training program was designed to build confidence in the caseworker regarding his or her professional ability to deal effectively with the alcoholic in the context of his or her family.

(b) Change in Information

The training program included an introduction to the basic facts about alcohol abuse and alcoholism, its recognition and treatment, and a survey of community resources available to the alcoholic person.

(c) Change in Staff Effectiveness

A training intervention was designed to help promote increased staff capability in effective treatment.

(d) Change in Agency Policy

As a result of the intervention it was expected that alcoholics and their families would be admitted for service more frequently than had been customary, and would engage in therapy more readily.

6. Major Assessment Tools

In order to measure the areas selected for evaluation five major assessment tools were designed:

(a) Attitude-Opinion Questionnaire

(b) Caseload Questionnaire

(c) Trainee Individual Interviews.

(d) Alcoholism Information Questionnaire

(e) Executive Director's Questionnaire.

The relationship between the areas of evaluation and the major assessment tools is depicted in Table 1. Figure 1 displays the operational timetable for the training program and the evaluation measures.

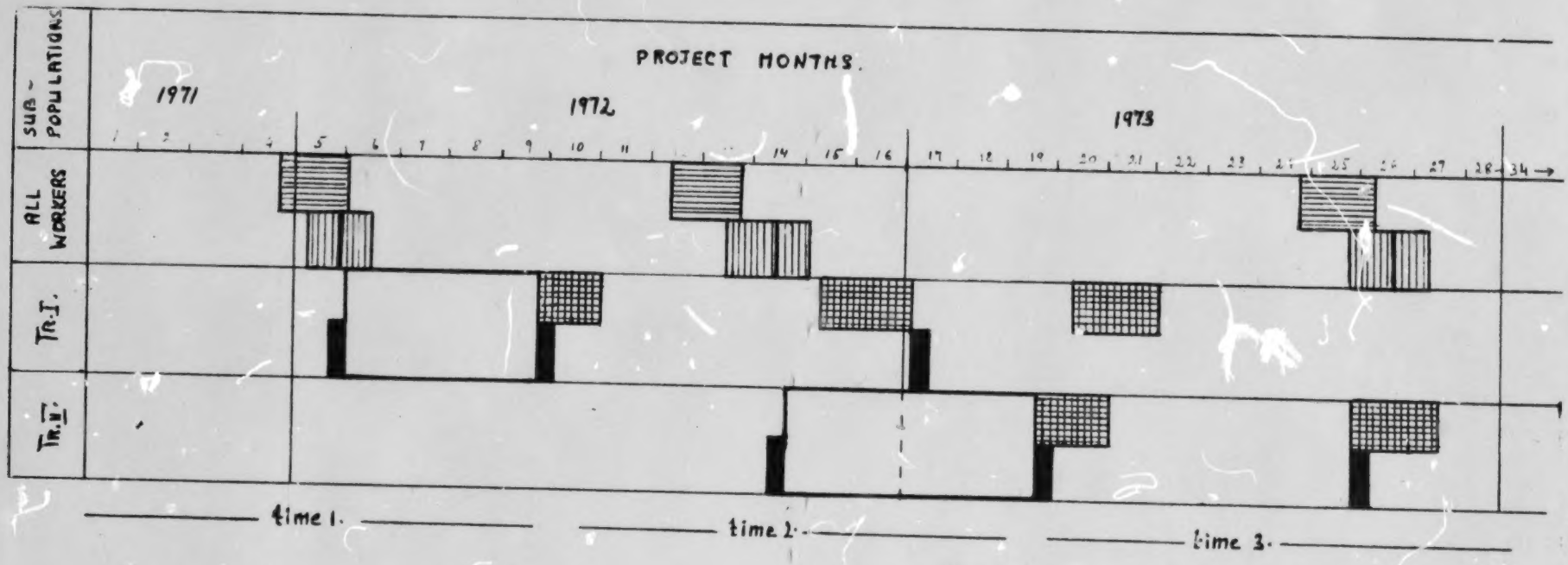
Table 1.

Areas of Evaluation and Corresponding Assessment Tools

EVALUATION AREAS	ASSESSMENT TOOLS
Change in Attitude	Attitude-Opinion Questionnaire Trainees Individual Interviews
Change in Information	Alcoholism Information Questionnaire
Change in Staff Effectiveness	Trainees Interviews Attitude-Opinion Questionnaire (Part I) Caseload Questionnaire
Change in Agency Policy	Executive Director's Questionnaire Brochures Annual Reports Caseload Questionnaire

Figure 1.

Time Table of Training and Evaluation Measures



A-0 Questionnaire — represents the approximate time period during which A-0 was administered

CL Questionnaire — represents the approximate time period during which CL was administered. Data on this questionnaire referred to active caseload on specific days during each time period. Heavy vertical line represent the specific day.

Training Period

Information Quest. — represents the approximate time period Information Quest. was administered

Individual Interviews — represents the approximate time period

Chapter 3

INSTRUMENTS

A. Executive's Questionnaire

The questionnaire (Appendix A) was designed to gather baseline data and attitude/opinion information from the executive directors of participating agencies. In addition to basic agency characteristics, e.g., number of staff, number of locations, the questionnaire included a series of specific questions regarding the agency's policies and practices relative to "problem drinking".

This questionnaire also included a section on attitudes. For this purpose 26 statements were adapted from previously used attitude scales, i.e., Bailey, M. Attitudes Questionnaire, designed for Alcoholism Demonstration Project: An Inter Agency Experiment conducted by Community Council of Greater New York; and Passey, G. E. & Pennington, D.F. Techniques for the Assessment of Scheduled Attitudes Toward Alcohol and Its Use. This questionnaire was administered at three intervals over the course of the project.

B. Attitude-Opinion Questionnaire

An attitude-opinion questionnaire (A-O) was developed for administration to all staff members at each participating agency (Appendix A). The first section on personal information and experience contained questions on background in specialized training approaches, experience with alcoholic clients, and certain personal characteristics.

The second section consisted of an attitude-opinion scale. Most items included in this section were adapted from previously used attitude scales, i.e., Bailey, M. Attitudes Questionnaire for Alcoholism Demonstration Project: An Inter Agency Experiment conducted by Community Council of Greater New York; and from Passey, G. E. & Pennington, D. F., Techniques for the Assessment of Selected Attitudes Toward Alcohol and Its Use.

The A-O questionnaire was administered at three intervals over the course of the project.

1. Construction of A-O Questionnaire

A pool of approximately 90 statements was gathered. The staff then submitted these statements to additional screening and sorting. Statements found to be ambiguous, redundant or whose face value did not seem to be pertinent to the study population were eliminated.

The remaining statements were analyzed by inspection for grouping by content into identifiable categories. Based on this analysis, four major categories were identified and defined. All statements appeared to fall into at least one category, and many into more than one. In addition it appeared that each statement could be classified on a continuum which corresponded to each pertinent category as a function of directionality and strength. The four categories and their respective continua thus identified were:

	Categories	Continua
I	General Attitude Toward Alcoholism	Permissive-Restrictive
II	Attitude Toward the Alcoholic Client	Acceptance-Rejection
III	Attitude Toward Self as Treatment Agent	Active-Passive
IV	Attitude Toward the Treatability of an Alcoholic Client and/or His Family.	Optimistic-Pessimistic

Definitions of Continua

Category I. Continuum: Permissive-Restrictive

A "permissive" score on this continuum indicates that the respondent's attitude toward alcohol and/or alcoholism is generally positive and relatively free from prejudice. A "restrictive"

score indicates a generally negative and relatively prejudiced attitude toward alcohol and/or alcoholism.

Category II. Continuum: Acceptance-Rejection

An "acceptance" score on this continuum indicates that the respondent has an accepting attitude toward the alcoholic person and that he is willing to relate to an alcoholic as a person having idiosyncracies, feelings, as any other person. A "rejection" score indicates an unwillingness to relate to an alcoholic and/or to consider him/her as a human being worthy of all privileges and considerations others have.

Category III. Continuum: Active-Passive

An "active" score indicates the respondent has a positive attitude toward self as an effective therapeutic agent. A "passive" score indicates feelings of helplessness and passivity on the part of the therapist.

Category IV. Continuum: Optimistic-Pessimistic

An "optimistic" score indicates that the respondent's attitude is that the alcoholic person's chances of being treated successfuly are the same as other clients. A "pessimistic" score indicates an attitude that the alcoholic person has a poor prognosis for successful treatment.

Therefore, in terms of the A-O questionnaire an overall positive attitude toward alcohol, alcoholism and self as a treating agent would consist of permissive, acceptance, active and optimistic responses to the pertinent items.

Criteria for Inclusion

The first criterion for inclusion of a statement was its fit into one or more categories. Statements which were not judged to fall into any category were eliminated. A second criterion for inclusion of a statement within a category was based on whether it was judged to have a clear directionality on the category's continuum:

Judgement 1. Decide to which category or categories the statement related.

Judgement 2. Determine where to place each statement on a 10 point continuum corresponding to the categories identified in judgement 1.

A panel of 7 independent raters was assembled to make the two judgements with respect to each of the 59 statements in the questionnaire pool.

Arbitrary cut-off points for identifying a scoreable statements to be included in the final questionnaire were determined in advance of the raters' response.

Thus, for inclusion in the final form a statement must have been judged to relate to at least one (1) category by at least four (4) judges and the average score of the continuum ratings must have fallen within either the 1-4.5 range or the 6.5-10 range (designed to eliminate neutral and/or ambiguous statements). Statements which met these criteria on one or more factors were included as scorable statements.

Examples of four statements which met the criteria for inclusion in the A-0, plus their categories and continuum scores, are listed below:

> "Young people should be taught how to use alcoholic beverages by their parents."
>
> Category I, continuum score 2.2 (Permissive)
>
> "People who become alcoholics are usually lacking in willpower."
>
> Category II, continuum score 9.0 (Rejection)
>
> "The motivation of the alcoholic for treatment is not affected by external duress."
>
> Category III, continuum score 7.5 (Passive)
>
> "The proportion of effective treatment in alcoholism can be equal to effective treatments of any other category of clients."
>
> Category IV, continuum score 2.0 (Optimistic)

Table 2 summarizes the final composition of the A-0 questionnaire.

Table 2.

Categories, Their Respective Continua and Distribution of Scorable Items.

Categories	Continua		Total no. of Scoreable items
	No. of Items	No. of Items	
General Attitude toward Alcoholism	Permissive 9	Restrictive 9	18
Attitude toward the Alcoholic Client	Acceptance 6	Rejection 19	25
Attitude toward Self as treatment Agent.	Active 2	Passive 14	16
Attitude toward Treatability of Alcoholic Client and his Family	Optimistic 8	Pessimistic 24	32

Scoring System

A total of 50 statements, scoreable on one or more categories, were identified by means of the procedures described above. The questionnaires are scored on the appropriate continuum for each applicable category using the following procedure:

(a) All responses are considered to be dichotomized, i.e., Agree or Disagree.

(b) Within each pole of the dichotomy a response is weighted. For example, a respondent has the following range of choices for each statement - "Definitely Agree," "Agree", "Disagree," "Definitely Disagree". The extreme responses carry a value of ±2 and the intermediate responses a value of ±1.

(c) A total score is calculated for each category by adding up the values of the agreements with the predetermined extreme of each continuum, i.e., permissive, acceptance, active, optimistic. For example, a statement which has been rated a Permissive on Category 1, and with which a respondent "agrees", receives one point on Permissive; a statement which has been rated as Restrictive with which a respondent "definitely disagrees" receives two points on Permissive; a statement which is rated "restrictive" and with which the respondent "agrees" receives minus one point on Permissive.

(d) Summation of the total scores from each of the four categories yields a full scale score.

(e) The range of scores for the 91 scoreable responses is -182 to 182.

Category Intercorrelations

Pearson product-moment coefficients were calculated for the all permutations between each category and the full scale for each administration of the A-O Questionnaire. The results are contained in Table 3.

Table 3

Correlation Coefficients for Categories of A-O Questionnaire Times 1, 2, and 3.

Category	II	III	IV	FS
I	.33[a] .39[b] .49[c]	.22 .29 .27	.29 .34 .27	.47 .57 .51
II		.74 .52 .69	.84 .75 .74	.94 .84 .87
III			.80 .61 .73	.85 .54 .81
IV				.96 .87 .86

a. First administration, Time 1 - N=113
b. Second administration, Time 2 - N=114
c. Third administration, Time 3 - N=106

Inspection of the intercorrelations reveals, over a period of time, a relatively stable relationship among the four categories and the full score. On the basis of the stability of each category's relationship to the full scale and the high positive correlations, only, only full scale scores were used in the analyses of A-O scores for this project.

Reliability of A-O

A measure of the A-O's reliability was derived by means of a sub-study involving thirteen (13) subjects. All subjects were professionals and comparable in level of education and area of occupation to the workers employed in the family agencies. They each responded to the A-O on two occasions, approximately one week apart. No interventions designed to influence the Ss attitudes related to alcohol and alcoholism were introduced during the period between administrations.

The test-retest estimate of reliability yielded a correlation coefficient of +0.81.

C. Alcoholism Information Questionnaire

The Alcoholism Information Questionnaire (AI) was developed from a pool of multiple choice, true and false, and completion items (Appendix A). Questions were contributed to the pool from three sources:

(a) Lecturers scheduled for the lecture series included in the first round of training were requested to submit four multiple choice questions related to their presentation. (Questions were received from approximately 20% of the lecturers).

(b) Questions were developed by the staff on areas related to lecture topics not covered by questions received, i.e., lecturers' topics for which they did not submit questions.

(c) Existing alcoholism questionnaires were surveyed; questions considered pertinent to the focus of training and trainee population were identified and selected for inclusion in the questionnaire.

Two forms of the AI were constructed, Form H and Form L. They were balanced by inspection in an effort to keep the forms parallel both in terms of content and difficulty. Based on the mean scores of a total of 39 administrations, 18 Form H's and 21 Form L's, the two forms appear to be approximately equivalent in terms of difficulty. The mean for Form H was 36.5 and the mean for Form L was 34.0. A test of the difference between the two means was non-significant, i.e., t=0.9, df=37, p .20.

A third AI form, Form BK, was constructed by combining Forms H and L, and by eliminating 12 items which were clearly overlapping.

1. Scoring

Each form H, L, and BK, had a different number of correct responses, i.e.:

(a) Form H: 46 items, 57[1] correct responses

(b) Form L: 46 items, 48[1] correct responses

(c) Form BK: 80 items, 95[1] correct responses.

The sum of correct respones on each form is calculated, yielding a raw score. Form H was used as the basis for standardizing the scores for the three forms. Form L raw score totals are multiplied by a corrective factor of 1.5 and Form BK raw score totals are multiplied by a corrective factor of 0.6. In this manner the raw scores on Form H are comparable to the corrected scores on Forms L and BK, and the range of scores for all three forms is 0 to 47.

2. Administration

All trainees responded to the AI at three distinct points in time;

(a) Immediately prior to beginning the training program,

(b) Immediately after completion of the training program,

(c) Six months following completion of the training program.

Forms H and L were assigned randomly on the first administration and counterbalanced on the second administration.

---

1. Each correct response was assigned a value of one.

D. Caseload Questionnaire

A caseload information questionnaire (CL) was designed for individual administration to all caseworkers in each participating agency. The CL requested the workers to specify the number of active cases carried by them to complete questions concerning detailed information on the cases in which "drinking was a problem,"[2] i.e., alcohol related cases. The data categories were selected according to the measures specifically geared to testing the goals of the project. However, strong consideration was also given to collecting the kind of information that would be readily available to the workers and that would appear on records maintained by comparison agencies.

The CL was self-administered at Times 1, 2 and 3. The workers were instructed to respond on the basis of their active caseload at a specific time i.e., open cases on a given date.

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[2] For purposes of this study "drinking problem" referred to a condition in which past or present consumption of alcohol beverage occurred in quantities sufficient to interfere with individual and/or family functioning and fulfillment of social roles, and which was still considered an issue in treatment.

Chapter 4

ENTRY PROCESS

The development of the proposal which led to the current project took place during 1968-69. In retrospect, it appears that at that time the family agencies included in this study had an orientation toward the alcohol problemed family which is some aspects differed from their orientation a few years later when the funds had become available. Based on the results of a 1969 pilot survey of family agency caseworkers, alcoholism was considered to be an extremely difficult, if not impossible, behavior to correct; furthermore, few caseworkers were viewed, or viewed themselves, as capable of productively undertaking the treatment of alcoholism disorders. Two years later (1971-72) when the project had become operational, the administrators of these agencies, although still believing that their staffs were not performing at an optimal level of competance in the treatment of alcoholics, thought that in general the workers were handling the alcohol related cases quite competantly. Moreover, although at the inception of this project alcohol related problems were a factor in a substantial percentage (12-14%) of the general caseload, the agency administrators did not believe that meeting the needs of alcoholics more effectively was a high priority.

The changed circumstances became especially significant in view of the financial crunch confronting these agencies. That is, at a time of increased demand for agency services from the public, the amount of available monies had decreased. Consequently agency administrators became more concerned about the fee loss that would result if caseworkers used agency time to participate in a training project. Thus, even though the revised training grant called for training only 50% of the agencies' staff in contrast to the original request for 100% participation, the agencies' administrative leadership perceived even this curtailed level of participation would have substantially reduced caseworker time available for fee-deriving services.

The conditions under which the project was to begin were further aggravated by feelings of resentment expressed by some of the administrators over not having been involved in the process of proposal development and selection of the training team.

The project team, therefore, was intially confronted with the task of re-negotiating the family agencies' involvement in, commitment to, and endorsement of the project in a manner which was acceptable and meaningful to all parties. The staff devoted substantial amounts of time and energy to meetings and correspondence with executive level personnel in the participating agencies during this renegotiation process.

Finally, between the time in which the proposal was developed and the project funded, a new dimension of the renegotiation was introduced through a change in professional ethos. Agency administration could no longer be expected to require their workers to participate in any training and research activity. Each caseworker was now considered individually responsible for his or her decision to participate in the training and in the numerous auxiliary research activities. It became apparent that the research and training programs would have to be presented directly to caseworkers in an effort to enlist their involvement and cooperation. This effort was begun in part by arranging full staff meetings for all branches of each agency in order to present to the staffs the research and training components of this project. Four meetings were scheduled and presentations were made to the staffs of participating family agencies. Approximately 80% of the professional employees were in attendance at these presentations.

The entry phase was completed in December 1971. The agencies and their staffs were participating in the project with varying levels of enthusiasm. One index of caseworkers' motivation is summarized in Table 4.

Table 4.

Motivation of Staff for Participation in Training Program at Time 1.[1]

Level of Motivation	Agencies									
	FSA[a]		FC&G[b]		Reg(W)[c]		Camb.[d]		Totals	
	n	%	n	%	n	%	n	%	N	%
High	25	42	5	20	6	43	3	33	39	36
Neutral	18	30	9	36	5	36	5	56	37	34
Low	17	38	11	44	3	21	1	11	32	30
Totals	60	100	25	100	14	100	9	100	108	100

a. Family Service Association of Greater Boston
b. Family Counseling & Guidance Centers
c. Family Counseling Service (Region West), Inc.
d. Family Counseling Service of Cambridge

1. Motivation was measured by response to Item 7 on UCS Alcoholism Questionnaire, Appendix A.

Chapter 5

MAJOR INTERVENTION

The design of this project called for training of caseworkers in the treatment of alcohol problemed families as its major intervention.

M. Bailey (1973) observed that although family agencies are more likely to think in terms of the total family than other treatment resources, this is only theoretically true in alcohol related cases because "family agencies have never been very successful in engaging the alcoholics themselves in treatment, but have worked largely with the wives and children (p.25)." Bailey referred to the design of the training introduced in her project as bringing "family caseworker practice in alcoholism cases closer to the ideal model of family casework practice (ibid)."

As with the Bailey program, this project was based on the assumption that alcohol abusers and alcoholic persons can be treated for their alcoholism in a family agency setting. It was also assumed, as Bosma (1972) has pointed out, that "First and foremost, the individual [in this case the caseworker] must be aware of the problems of alcoholism and believe that the alcoholic can be helped."

1. Theoretical Foundation of the Training Program

The Boston Family Institute (BFI), the agency which provided the training program, held the view that families are living, dynamic "systems", operating multi-dimensionally in their own physical, psychological and cultural space. Each family has its own nature, dynamics and problems; each is a separate and distinct entity, unlike any other. Like all societies, families reflect the natures of their members while at the same time helping to create them. This interplay of person and group in reciprocal influence -- the psychopolitics of family life -- is the forming force in the creation of each family's unique character and way of life. Any individual problem creates and reveals a problem within the family. There are, in this special sense, no children or individual family members with problems -- there are only families with problems.

The structure of the BFI training program was based on dynamic personality theories, small group and games theory, some of the broader areas of sociological theory (principally the tradition of equilibrium theory) and the recent applications of system theory to human systems.

2. Broad Aims of the Training Program

The training program started with the assumption that first rate service for alcoholics and their families could only come about by first reducing the apathy, misinformation and bias of

professionals. While professionals possess the basic skills for dealing with alcoholics, they cannot apply these skills effectively without modifying established patterns of negative attitudes and pessimistic beliefs. The professional must also gain additional factual knowledge and a theoretical understanding about alcoholism and its treatment. The training would emphasize the type of family therapy which deals with the family-as-unit instead of treating the alcoholic or his spouse as isolated individuals.

3. Specific Aims of the Training Program

Attitude Change:

(a) To communicate to the practitioners that the alcoholic can be treated, thus increasing the chance of the alcoholic's recovery by changing the pessimistic attitudes of the professionals.

(b) To remove the social stigma surrounding the alcoholic and to develop an increasingly objective attitude.

(c) To increase the family caseworker's knowledge, comfort and confidence in regard to treating the alcoholic.

Information Transfer:

(a) To teach caseworkers about the etiology, nature, and therapeutic control of alcoholism in its different forms.

(b) To increase the practitioner's understanding and skills in the "systems" approach to family therapy.

Increased Effectiveness:

(a) To change discriminating admission policies practiced overtly and covertly be agencies and intake workers.

4. Structure of the Training Program

To accomplish training goals outlined above, BFI designed a training program structured aound the two major conditions of learning: Involvement and Inquiry. The training team used experience based learning and information input as their educational tools.

Thus, the training program included two major segments: An Action-Process Seminar and Lecture Series.

The Action Process Seminar focused on substantive behavioral science data and on the trainees' own attitudes, awareness, and relational involvements. Priorities in this segment of training were: First, experiences in the group; second, experiences with patients; and third, experiences with instructors. The emphasis in the seminar was on experience first and on conceptualization later. The basic assumption of the training program was that learning which stresses direct contact with the self, other trainees, instructors, and family units is more meaningful and effective than learning without this structure.

The Lecture Series presented formal instruction in the history, psychology, sociology, physiology of and community resources for alcohol abusers and alcoholism.

Trainees were also requested to attend at least one meeting of Alcoholics Anonoymous, to visit a de-toxification center and to be involved in the treatment of a family with an alcohol problem while participating in the seminar series.

Appendix B contains the conceptual foundation, "syllabus" and Lecture Series outline submitted by BFI.

The training program for the second round was modified based primarily on the feedback from trainees, agency executives and supervisors. The "syllabus" submitted by BFI for the second round is also included in Appendix B.

5. Recruitment of Trainees

(a) First Round of Training

All caseworkers were informed about and familiarized with the project's training and research components by means of in-person presentations. These presentations were made by the Directors of BFI and the Project Director at four major agency locations. The opportunity to ask questions and to discuss the proposed project was provided to the prospective trainees in an effort to enlist their support for the collection of data and their participation as volunteers in the training program.

(b) Second Round of Training

Following completion of the first round of training, those workers who participated made presentations of their training program experiences to their colleagues during scheduled staff meetings.

Thus, all workers, supervisors and administrators in each participating agency had the opportunity to familiarize themselves with the strengths and weaknesses of the training program.

6. Project Team's Role in Intervention

It was the project team's responsibility to arrange meetings and training times and to be available for consultation with the trainees. These activities had the effect of stimulating and maintaining interest in the training program and in the problems of alcohol abuse and alcoholism.

The project team was also engaged in communicating with agencies regarding each of the three rounds of questionnaires sent to all the staff members of the participating agencies. It is assumed that these activities, as well as the completion of the questionnaires themselves, helped to create a focus of attention on alcoholism as an independent problem.

Finally, the focus on alcoholism was maintained by regular meetings with the agency executives. Earlier in the project, these meetings were primarily arranged in order to work through

the basic logistics of the training program. The meetings were later called by the project staff for the purpose of hearing the executive's views on the training; to share with them some of the early data that the project team had compiled; and to exchange ideas on how the expected effects of the training program could be maintained and expanded in the service of alcoholic persons and their families. Finally, the meetings were called to insure the continual feedback of the executive's views on the training program and for the planning and formulation of a new proposal to NIAAA.

The intended intervention was also given support by the positive working relationships that resulted from the participants' contact through meetings and correspondence.

7. Relationship to Training Organization (Boston Family Institute).

The relationship between the project and its sub-contractee began with a spirit of collaboration and sharing for the purposes of developing the most effective intervention and the most meaningful evaluation. Unfortunately, this model gave way to one in which the sub-contractee functioned in an almost totally autonomous fashion and was not responsive to the project staff's efforts to integrate and coordinate the functioning of the project.

The project team, not having been involved in the proposal development stages, was also not involved in selection of the organization subcontracted to provide the training. In contrast Boston Family Institute (BFI) Co-directors did participate in designing the training section contained in the original proposal.

The project director initiated negotiations between BFI and the project team at the earliest possible date following his appointment. Only one of the two BFI directors was available during the first two months of negotiations and planning. A model of collaboration and sharing between the project team and training group was established.

In the process of the planning meetings, commitments and timetables were mutually established. However, with passing time it became increasingly clear that although the face-to-face meetings were promising, the delivery on promises by the training

group was at best late and came only after numerous reminders. On some specific commitments there has been no delivery, e.g., detailed syllabus of training program, descriptions of the training program's behavioral objectives.

Furthermore, when the second director of BFI became involved, and the other director in terms of active involvement in the project rapidly faded into the background, he made it very clear that BFI considered mutual planning and collaboration unnecessary. This attitude resulted in blocking the project team's objectives to work collaboratively with BFI in order to effect the best possible intervention and be in an optimal position to measure change.

Meanwhile, the administrators of the participating agencies were demanding re-assurrances that their participation in the project was going to prove worthy to the agency. They were somewhat suspicious that the training program's focus on alcoholism would be inadequate; they wanted to see a syllabus and an outline of the theoretical basis of the training; they wanted schedules and other details pertinent to their planning and decision making. However, without BFI's responsiveness the project staff was unable to meet the demands from the administrators. Thus, although the relationship of the project to the

agencies during these early stages was delicate and tentative, and although the solidification of the relationships between the project and the agencies required responsiveness, responsibility and on-time delivery of commitments, without BFI's cooperation the project staff were frequently unable to respond adequately.

The difficulties were compounded as BFI began to exhibit a low level of commitment to development of essential preliminaries in preparation for the training program. They especially tended to avoid dealing with the need for emphasis on alcoholism. Communication between the project team and BFI directors became increasingly more difficult, more strain was introduced and delivery of the training program for the first round seemed to suffer accordingly.

Among the results of BFI's reluctance to handle the alcoholism input in the first round of training were:

a. Many disgruntled lecturers who felt that they received inadequate information re their role in the series.

b. A lecture series which was not integrated with the experiential segment of the training program.

c. Lectures which were viewed by a clear majority of the trainees as boring, redundent, confused, unrelated to each other and unrelated to what was being taught in the experiential training sessions.

d. Construction of an information questionnaire which did not stem directly from the content presented in the lecture series.

As the project evolved, it became clear to the project staff that a scenario had been established and its attendant frustrations and difficulties were likely to be repeated again and again. Nevertheless, and perhaps naively, the staff continued their attempts to foster functional communications with the training staff. The attempts ranged from friendly reminders re failure to deliver, to firm requests for immediate delivery, to threats of non-reimbursement. BFI frequently responded with messages of resentment and indignation rather than delivery of the information requested.When delivery did occur, it was either last minute or late, and occasionally incomplete. When delivery did not occur, the project staff was forced to modify their work accordingly.

An important area in which the BFI staff did meet their obligations on time was in their delivery of the training package, i.e., training was carried out as scheduled. Further, in response to the project team's sharing of feedback from trainees, supervisors and administrators, BFI did integrate the didactic alcoholism content into the flow of the experiential sessions during the second round of training. However, there is little

doubt that due to failings of BFI and to the strain between the project team and sub-contractees, the intervention results were partially influenced and that the project suffered accordingly.

The failure to deal more effectively with the BFI sub-contract can be attributed to two basic circumstances:

(a) Reluctance to terminate the contract with BFI, especially during the first year, out of concern that this action would disrupt the project in very significant ways, and possibly even result in its termination.

(b) The project director and the principal investigator did not respond to BFI in a congruent fashion. The principal investigator was much more tolerant and willing to accept their repeated promises of cooperation. At critical times this split served to undermine the stance taken by the project director.

In the project's planning stages the decision to split the training and evaluation functions was based on an attempt to keep the research as "clean" as possible. In doing so, loss of full control over project management was undermined. The trade-off turned out to be a poor one, since it is believed that the loss of control not only influenced the results of the intervention in the negative direction, but also had a detrimental effect on the evaluation process.

In August 1969 the NIMH site-visit team was unhappy about the sub-contractual arrangement proposed in the project's application and requested that the training expenses be detailed and carried as a direct cost. Retrospectively the project staff

finds itself in agreement with the site-visit team's recommendation and believes that a non-contract approach to the training would have strengthened the positive effects of the intervention.

PART II

RESEARCH FINDINGS
and
IMPLICATIONS

CHAPTER 6.

ANALYSIS OF ATTITUDE CHANGE

A major purpose of this project's intervention was the improvement of attitude's towards alcohol and alcoholism of all agency staff. Underlying this purpose is the assumption that improvement in this attitude is positively related to improvement in the quality of service delivery to alcohol problemed clients. It was further postulated that attitude change would result directly from participation in a training program introducing a family systems approach to treatment of alcoholic persons, and that the produced change in those who were trained would "ripple" out to their co-workers, having a similar effect on them.

The A-O questionnaire was the principal measuring instrument used for assessing attitude change. This chapter is devoted to an analysis of A-O results.

1. Similarity of A-O Scores Among Agencies

Prior to a detailed analysis, it was considered important to establish that the agencies on the basis of measured attitude levels were sufficiently similar to justify pooling the data and treating it as having been drawn from a single population.

A-O scores by agency for t. 1 and t. 3 were subjected to an analysis of variance (Games and Klare, 1967).

F scores of 2.53 and 2.07 were obtained for times 1 and 3 respectively.

Table 5.

Comparison of A-O Scores for Staff by Agency, t. 1 and 3

time 1.

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	Obtained F Value
Between Agencies	3	7051	2350.3	2.53
Within Agencies	109	101,169	927.2	
Totals	112	108,120		

time 3.

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	Obtained F Value
Between Agencies	3	4904	1634.7	2.07
Within Agencies	102	80,713	791.3	
Totals	105	85,617		

Neither of the obtained F scores closely approached the .05 level of significance of F = 3.97. The A-O scores of

workers in the participating agencies appear to be sufficiently homogeneous to consider them as having been drawn from the same population. These results also provide a basis for generalizing beyond the population from which the data was collected.

2. Analysis of A-0 Practice Effect

In order to properly analyze change in A-0 scores, the repeated administration of the A-0 questionnaire requires consideration of the presence of a "practice effect". The data in Table 6 are relevant to this consideration.

Table 6

Mean A-0 Scores of Agency Staff Employed Throughout the Project Period.

Staff	N	Time		
		1	2	3
CW - (I & II)	44	50.1	43.4[a]	56.0
Tr. I	14	40.8	55.[illegible]	51.4
Tr. II	19	47.5	46.[illegible]	55.4
Totals	77	47.7	49.[illegible]	55.0

a. Based On N = 40.

The above table shows that average scores for both non-trainees and Tr. II decreased between the first and second

administrations, while Tr. I scores increased. This pattern was reversed between the second and third administrations.

To further illuminate the influence of a "practice effect", the A-0 scores for caseworkers who were not yet on staff when the project was initiated, i.e., t. 1, and were employed during t. 2 and t. 3 are contained in Table 7.

Table 7

Mean A-0 Scores of New Agency Staff Employed After Time 1.

New Staff	N	Time	
		2	3
Non-Trainees	13	43.7	38.6
Tr. II	2	35.5	49.5
Totals	15	42.6	40.1

The magnitude and direction of A-0 score change for these two sub-samples is basically the same as the A-0 score change for the two comparable groups, i.e., CW-(I & II) and Tr. I, for times 1 and 2 (Table 6).

The pattern of decrease in A-0 scores in the absence of a direct intervention was also observed in a realiability study of the A-0 questionnaire in which 13 professionals

participated. On repeated measures administered approximately one week apart, their mean A-O scores decreased 6.8 points, from 43.0 to 36.2.

Thus, it appears that the A-O questionnaire has a "practice effect", and the effect is negative, i.e., scores on the average diminish when no intervention is present. Thus, in view of a negative "practice effect", an increase in A-O score related to the intervention is further enhanced.

3. Analyses of Selected A-O Results

In order to maximally measure the intervention's impact, only workers employed during the entire project period were considered in the following analyses. Thus, each worker functioned as his or her own control and any results from workers who were not exposed to the total intervention[1], which may have"masked" a true effect, were eliminated. Repeated measures on the A-O questionnaire for times 1 and 3 were available on a total of 77 workers (Table 8).

1. For example, workers who left the agency during the project period and workers hired after times 1 and 2.

Table 8

A-O Scores for Workers
by Agency, Times 1 & 3.

Agency	N	A-O Scores		
		Time 1	Time 3	Time 3-1
BC&G	21	46.7	51.6	4.9
BFS	39	50.4	58.5	8.1
Reg. W.	14	42.6	54.6	12.0
Camb.	3	44.7	34.0	-10.7
Totals:	77	47.7	55.0	7.3

t = 2.62 *p < .01

The change in A-O scores for the 77 agency personnel is significant and in the predicted direction. The pattern of mean difference scores (time 3-1) takes on added significance when considered in the context of proportion of agency staff participating in the training program (the Cambridge agency was excluded due to the small number of workers and unusual staff loss during the project period.) The proportion was developed for each agency by tabulating the numerator and denominator as follows:

Numerator - total number of trainees.

Denominator - total number of staff members eligible for participation during the two phases of recruitment.

Table 9

Staff Eligible for Training Program and Proportion of Trainees.

Agency	Eligible Staff	Trainees	%
BC&G	39	6	15
BFS	72	19	26
Reg. W.	17	11	65
Totals	128	36	28

It is evident that in this sample of three agencies there is a perfect positive correlation between size of increase in A-O scores and proportion of agency staff trained, i.e., the greater proportion of staff participating, the greater the increase.

Further, the mean difference scores, time 3-1, of three identifiable groups, i.e., Tr. I, Tr. II and CW - (I & II), were examined (Table 10).

Table 10

Mean Difference Scores for Staff Groups, Time 3-1.

Staff	N	$\bar{D}$
Tr. I	14	10.6
Tr. II	19	7.0
CW-(I & II)	44	5.9
Totals	77	7.2

An analysis of variance to test the independence of the mean difference scores yields an F of .20 (Table II), indicating that the differences observed are not significantly different.

Table II

Analysis of Variance of Mean Difference Scores for Staff Groups, Time 3-1.

Source of Variation	df	Sum of Squares	Mean Square	Obtained F value
Between Groups	2	241.5	120.8	.20
Within Groups	74	44,212.8	597.5	
Total	76	44,454.3		

Primarily due to a very high within groups variability, the AV does not indicate independence among the means. However, the pattern of mean differences, i.e., Tr. I have the greatest amount of absolute change in A-O score (10.6 points), followed by Tr. II (7.0 points) and the remaining caseworkers (5.9 points), is consistent with an expectation of levels of change resulting from a combination of direct and indirect interventions.[2.] This pattern becomes even more pronounced when the percent increase in score, i.e., difference score/t. I score, is calculated. Table 12 summarizes pertinent data.

Table 12

Summary of A-O Scores for Staff Groups

Staff	N	A-O Scores			% Increase
		Time 1.	Time 3.	Time 3-1.	
Tr. I	14	40.8	51.4	10.6	26.0
Tr. II	19	47.5	55.4	7.9	16.6
CW-(I & II)	44	50.1	56.0	5.9	11.8
Totals	77	47.7	55.0	7.3	15.3

2. Those workers who participated in the direct intervention, i.e., training, would be expected to demonstrate the greatest change and those who were only indirectly influenced, less change. The ordering of Tr. I and Tr. II receives closer attention in succeeding portions of this report.

The differential impact on the trainess' A-O scores, as an immediate function of the training intervention, was measured by calculating difference scores on repeated measures over the pertinent time periods. For Tr. I, the average change in score from before training (t.1) to after training (t.2) was 14.9 points. For Tr. II the average change in score from before training (t.2) to after training (t.3) was 9.9 points. These results were compared by the t test as tabled below.

Table 13

Test of Mean Difference Scores on A-O Between Tr. I & Tr. II

Staff	N[a.]	$\bar{D}$	S.D.
Tr. I	16	14.9	25.9
Tr. II	21	9.9	19.0

t=0.68 P<.50

a. Training group I lost two workers before time 3; training group II contained one worker who was not employed at Time I and one who did not complete an A-O at t.1.

The analysis indicates that the impact of the training intervention did not differentiate the two training groups on the basis of change in A-O scores. Both groups improved their A-O scores following their respective training periods.

Further analysis, using caseworkers who did not participate in the training programs as a control group, reveals a more detailed picture. A comparison between Tr. I and all other caseworkers (including those who were eventually to become Tr. II, since they had not yet been identified), on change in A-O scores following the intervention of the first training program[3], yields the results contained in Table 14.

Table 14

Mean Difference Scores on A-O of Tr. I and CW-(I)

Staff	N	$\bar{D}$	S.D.
Tr. I	16	14.9	25.9
CW-(I)	81	-1.4	23.2

$t=2.53^a$ $^*P<.01$

a. A sub-analysis in which CW-(I & II) was substituted for CW-(I) yielded a $t= 2.51$, $^*P<.01$.

3. A-O difference score between t.2 and t.1.

Thus, Tr. I not only increased their average score by 14.9 points, but this increase was significantly different at the $p<.01$ level from the change (-1.4 points) for those workers not participating in the first round of training.

A parallel analysis between Tr. II and all other workers (not including Tr. I since they had already participated in the training) for the period following the second training program[4] yields the results contained in Table 15.

Table 15

Test of Mean Difference Scores on A-O Between Tr. II and CW-(I & II)

Staff	N	$\bar{D}$	S.D.
Tr. I	21	9.9	19.0
CW-(I & II)	51	7.7	18.1

t=0.46 P<.50

It is important to note that the amount of average change in A-O scores for Tr. II, pre-to post-training, does not differ significantly from the amount of change

4. A-O difference score between t. 3 and t. 2.

recorded during this same time period by workers not enrolled in the training program, and that the A-O scores changed in the desired direction.

Thus, while the increase in attitude scores over the project's course is not statistically different between trainees and non-trainees, there does appear to be a differential outcome, immediately following training, between the two groups of trainees. Though both groups increased their scores, when considered against the backdrop of a control group, only Tr. I seem to have made a significant increase directly attributable to participation in the training program. The increase for Tr. II could be attributed to the existence of a "ripple" effect created by the project's existence in the agencies, since the increased positive effect on attitudes generated in Tr. II and other workers was at approximately the same order of magnitude. This finding will receive more detailed attention in Chapter 10.

Chapter 7

ANALYSIS OF CHANGE IN TRAINEE

A. Trainees 1.

The design of the project called for training a maximum of 60 caseworkers, thirty in each round of training. Thus, 30 caseworkers were eligible to become trainees in the first round of training.

1. Recruitment

In-person, group presentations by the research and training staffs were made to the caseworkers at four major offices of the four participating agencies. The presentations were designed to acquaint the agencies' personnel with both the training and research components of the project. Immediately after the presentation or within the month following, workers from the participating agencies had the opportunity to volunteer for the first round of training.

In the event that more than thirty caseworkers applied for the training program, the following selection procedure was adopted:

> Trainees will be selected randomly, taking into consideration the size of each agency, i.e., approximately 25% of each agency's workers will be in training in round one.

First preference in each agency will be given to full time workers. Part-time workers in each agency will be considered only after the pool of full time workers has been exhausted.

In all, 29 workers had volunteered to participate in the first round of training. However, before the training began, 12 of the volunteers withdrew their applications. The reasons for withdrawal included: projected over-commitment, inconvenient schedule of the training sessions, recommendation to withdraw by the staff director or personal therapist. Some workers did not wish to share their reasons for withdrawing.

Thus, 17 workers began and completed the first round of training.

Table 16

Trainee Enrollment - First Training Group

Phases	Agencies				
	FSA	FC&G	REG.W.	CAMB.	TOTAL
Dec. '71 Recruitment Period	13[a]	8	3	3	27
February '72 Beginning of Training	10	4	3	3	20
May '73 Completion of Training	10	1	3	3	17

[a] FSA started the month of December with 14 volunteers. During December, another person volunteered and two workers withdrew, leaving 13.

2. Time 1.

At the beginning of Time 1, i.e., the time at which the first round of A-O and CL Questionnaires were completed Tr. 1 were not yet identified as a training group, although some of these workers might have been in the process of deciding to volunteer for the training.

The average age of Tr. 1 was 32 years; they had had their MSW for an average of 8 years and had been employed at their agency for an average of 3.3 years. As a group, these trainees appeared somewhat different from the general pool of caseworkers on a number of variables.

Table 17

Summary of Attitude and Caseload Data for Tr. I, T.I.

Time	N	A-O				CL			
			Expected Success						
		Score[a]	a.r.cl.[b]	%g.cl.[c]	d.s.[d]	No.of Cases[e]	%a.r.cl.[f]	dr/pr.cl. total/cl[g]	dr/pr.cl. a.r.cl[h]
1.	17	40.0	31.5	63.1	31.6	21	16.7	4.7%	28.3%

a. Mean score on A-O questionnaire

b. Mean percent response to question 5 on A-O questionnaire, part 1, "Percent of alcoholic clients in your current caseload with whom you expect to realize maximum realistic goals."

c. Mean percent response to question 6 on A-O questionnaire, part 1, "Percent of clients in your current caseload, exclusive of alcoholics, with whom you expect to realize maximum realistic goals."

d. The discrepancy score (ds) was derived by subtracting the estimated rate of success with alcoholic clients from the estimated rate of success with general clients.

e. Mean number of cases carried by workers.

f. Percent of alcohol related cases out of total caseload.

g. Percent of problem drinkers who are primary clients out of total caseload.

h. Percent of problem drinkers who are primary clients out of total alcohol related caseload.

The average A-0 score (40.0) was 6 points lower than the average score (46.0) for the remaining staff. They expected to be successful in the treatment of 31.5% of the alcohol related cases and in 63% of the general cases. The success expectations of the other caseworkers were 35.4% and 62.4%, respectively. Thus, it appeared that Tr. I held a less positive opinion and attitude about alcohol and alcoholism and that as a group they were less optimistic about positive outcomes in treating alcoholic clients than were their co-workers.

The discrepancy between the trainees' relatively low score on the A-0 questionnaire, coupled with a lower expectation of success in dealing with alcoholic cases and a proportionally higher alcohol related caseload, suggests that; as a result of their wider experience in the treatment of alcoholism, these trainees tended to view the problem as a frustrating one and were more aware of the difficulties involved in working with alcoholic clients. This could account for their lower score on the A-0 questionnaire.

The caseload profile of Tr. I. indicated that although they carried a lower average caseload (21 cases per worker) than non-trainees (27 cases per worker), they carried disproportionally more alcohol related cases (11.8% of the total caseload and 17.3% of the alcohol related cases).

We might observe that without any training intervention those workers who were more familiar with the treatment of alcoholism, i.e., carried a larger proportion of alcohol related cases, tended to have a less positive attitude about alcoholism and its treatment. The workers who had a smaller proportion of alcohol related cases tended to be somewhat more positive and optimistic about such cases.

This same trend for Tr. 1. is evident when considering personal assessment of satisfactory vs. unsatisfactory therapy progress with alcohol related clients. All trainees were asked on the CL questionnaire "How do you rate your present work with the alcohol related primary client at this time?" Table 18 summarizes responses to self assessment of treatment progress with alcohol related clients.

Table 18

Self-Assessment of Treatment Progress with Alcohol Related Clients, Time 1.

Staff	Treatment Progress		Total cases
	Satisfactory	Unsatisfactory	
CW - (Tr.1)	199[a] 80%[b]	50 20%	249 100%
Tr. 1.	31 58%	22 42%	53 100%
Totals	230 76%	72 24%	302 100%

a. Number of cases

b. %'s are row proportions

$X^2 = 11.6$ $^*P < .001$

Tr. 1 viewed their work with 58% of their alcohol related primary clients as satisfactory or very satisfactory while the remaining caseworkers rated 80% of their work with this group of clients as being satisfactory or very satisfactory. Examining these data from the point of view suggested above, it might have been expected that Tr. 1. in the hope of alleviating their frustrations in working with alcohol problemed cases were highly motivated to engage in the training program and thus improve their skills. In examining responses to the question re this motivation (Question no. 7, A-0), it appeared that indeed there was a high

motivation among trainees to enter the training program (1.9)[1]. However, it was not clear from these data what the trainees were eager to be trained in. This ambiguity was reduced when the individual interviews of the trainees were examined. Referring to the time before entering the training program, the trainees were asked, "What were your expectations of this training program?" Nine (59%) of these workers responded that they wanted to improve their attitudes and skills in working with alcohol related cases; four (24%) stated they were expecting to learn only about the new family therapy techniques and had no expectations of learning about treatment of alcoholism, e.g., one respondent said, "I felt quite certain that alcoholism was merely a front for some training in family therapy." She based this view on the pre-training presentations of the trainers to be. Three (18%) other trainees expected to learn more about new techniques of therapy and in responding to the question did not mention alcohol related issues at all. One (6%) respondent did not have any expectations, as he knew nothing of the project and was assigned to it because no one else wanted to volunteer. Thus, 35% of these trainees, though highly motivated for training were not necessarily motivated for training in alcoholism.

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1. The scale was based on values of 1 for Very High Motivation through Neutral to 5 for Very Low Motivation, i.e., 1= Very High, 2= High, 3= Neutral, 4= Low, 5 = Very Low.

3. Time 2.

At t. 2, Tr. 1, had just finished their training phase. Table 19 summarizes attitude and caseload data for Tr. 1, at t. 2.

Table 19

Summary of Attitude and Caseload Data.

Time	N	A-O Score	A-O Expected Success %a.r.cl.	%g.cl.	d.s.	CL No.of cases	%a.r.cl.	dr/pr.cl Total/cl	a.r.cl.
1.	17	40.0	31.5	63.1	31.6	21	16.7	4.7	28.3
2.	16	56.3	47.7	66.7	19.0	20	21.4	8.9	41.7

The data above suggest that the training program did have an impact on Tr. 1 and that this impact was in the expected directions. Trainees' mean A-O score increased from 40.0 to 56.3, a difference of 16.3 points (41%), just as their optimism regarding treatment of alcohol related cases had increased, i.e., expectations of success in treating alcoholics had changed from 31.5% to 47.7%, a difference of 16.2%. It might be hypothesized that the increased optimism reflected the trainees' improved perception of self as a treating agent and seemed to become generalized slightly to trainees general cases. Their expected success with these cases, was raised from 63.1% to 65.8%, an increase of 2.7%.

Although at this time the general caseload for these trainees had decreased from an average of 21 cases to 20 cases per worker, the proportion of their alcohol related caseload increased from 16.7% to 21.4%, a difference of 4.7%. Even more striking is the increase in the disproportion, i.e., at t.2, Tr. I were carrying 10.5% of the caseload and 21.5% of the alcohol related cases. Equally impressive was the trainees' change in rating their satisfaction with the progress of their alcohol related primary clients. Although at t.1 the trainees felt "very satisfied" and "satisfied" in their work with 58% of the alcohol related cases, at t.2 this proportion rose to 73%. On the basis of the data, we might conclude that the training program was effective in changing the trainees attitudes, their professional practice, and their view of self as a treating agent.

These findings were not clearly supported by the verbal reports of the trainees during their individual interviews. For instance, in responding to, "How did your experience of the training compare with your expectations?", nine trainees (53%) thought their expectations were different from experience. Among these nine were eight trainees (47%) who originally expected to learn more about alcoholism. However, all but one of these respondents also added that in spite of the divergence from expectation, their experience was good and/or superior to their

expectations. Seven trainees (41%) responded that their experience was just as expected or better and here again the respondents consisted primarily of those workers whose motivation was oriented around learning more about family therapy.

Further, responding to the questions re change of practice the training had no effect at all on their practice of therapy and they did not single out work with alcoholism; four (24%) experienced change in their view and style of working with families and again alcoholism was not singled out; only two (12%) trainees felt they could, as a consequence of training, work better with alcohol related clients; one (6%) felt there was no change; and one (6%) did not know because she had no clients.

At the same time six (35%) of these trainees felt their attitude toward alcoholism had changed "some" in a positive direction: five (29%) felt it had changed a "little"; three (18%) thought it changed "a lot"; and one trainee (6%) did not feel there was any change.

4. Time 3.

T. 3 was approximately 14 months after Tr. I had finished their training phase. Table 20 summarizes the Attitude and Caseload data for Tr. I at time 3.

Table 20

Summary of Attitude and Caseload Data

Time	N	A-O				CL				AI[a]
		Score	Expected Success			No. of cases	%a.r. cl.	dr/pr.cl		
			%a.r.cl.	%g.cl.	d.s.			of	a.r.cl.	
1	17	40.0	31.5	63.1	31.6	21	16.7	4.7	28.3	38.1
2	16	56.3	47.7	66.7	19.0	20	21.4	8.9	41.7	38.3
3	14	51.4	51.7	65.8	14.1	22	17.9	8.6	47.9	42.6

a. Mean score on Alcohol Information questionnaire.

Data from t.3, indicates that approximately one year after the training program some of the trainees' gains began to taper off. Their A-O scores at t. 3. had decreased from 56.3 to 51.4. However, the difference in score from t. 1 to t. 3. is 11.4 points, representing a 26% increase. Thus, although the substantial gain demonstrated immediately after the training was not fully maintained, t. 1 to t. 3., difference scores seem to indicate that the training intervention did effect a degree of sustained change. The reliability of the change is further suggested by the continued trend of the trainees' increasing optimism in results of treating

alcoholic clients, i.e., having revised upwards their expectation of success by 16% at t. 2., they added another 4% at t. 3. An additional estimate of the trainees' level of confidence was developed by calculating the discrepancy score (ds) , i.e., the percent difference between estimates of success with alcoholic clients and general clients, one measure of the degree to which the workers perceived their work with the rest of their clients. Based on the training program's orientation, it was reasoned that workers, having experienced attitude change and acquired additional skills, would view the potential outcomes related to their treatment of alcoholic clients as being little different from the potential outcomes with general clients. Therefore, an index of confidence in themselves as a therapist with alcoholic clients would be the amount of disparity between the two estimates of success; the greater the disparity, the lower the confidence, and vice-versa. Tr. I. progressively decreased this disparity over the three points in time, principally by increasing their confidence in estimates of ability to be effective in treating alcoholic clients.

The change in the percent of alcohol related caseload for Tr. I drops more dramatically than the A-O score. Here the drop consists of 3.5%, however, the percent of alcohol related clients continues to be higher at t. 3 then it was at t. I by 1.2%.

A more sensitive measure of this change, however, is the disproportional amount of alcohol related cases carried by Tr. I compared to their share of the total caseload, i.e., 10.2% of caseload and 18.8% of alcohol related cases. In the context of the caseload data, however, what appears to be most significant is the consistently increasing change in the proportion of drinkers who are primary clients seen by the trainees. Whereas at t. 1. 28.3% of these trainees' alcohol related caseload consisted of the drinker, at t. 2 this proportion was raised to 41.7%, and at t. 3 it was further raised to 47.9%. Thus, from t. 1 to t. 3 there as an increase of 19.6%. Tr. I were now treating the drinker directly in increasing proportions and simultaneously expressing increased confidence in their abilities to do so.

Concomittantly, the trend described above in working with alcoholic clients was paralleled in the trainees' ratings of their progress with their alcohol related caseload. Tr. I in the progress of their work with this group of clients rated as "very satisfactory" or "satisfactory" at t. 1, 58% of their clients, t. 2 - 78%, and t. 3 - 84%. Thus, Tr. I expressed an increase in rated effectiveness of 26% from t. 1 to t. 3.

Tr. I also increased their AI scores in the six months following training, after registering no change immediately after the end of the training program. The results receive a more detailed analysis in section D. of this Chapter.

It appears, therefore, that Tr. I have not only been affected by the training program and that some of the effect was maintained more than one year past intervention, but that in addition some of the more significant measures of the effect indicate a continuation of positive change beyond a year's time after the training period had ended.

The above findings correspond with the trainee's evaluation of the training influence which they reported during the individual interviews six months after training. In response to, "what effect does the training program have on you now?", only one trainee (8%) responded that the effects had thoroughly dissipated (this was judged by her to have been due to the lack of theoretical underpinning in the program); four respondents (31%) thought that they had been opened up to new ways of therapy (use of space, use of self, non-verbal techniques); two (15%) felt they became more "loosened up" as therapists; three (23%) experienced themselves as continuing to be more confident in working with families; two (15%) felt that they gained a new view of family systems; however, only one response (8%) mentioned a difference in dealing with problems related to alcohol, i.e., increased respect for the role and activities of AA.

Seven (54%) of these trainees still use their learning about the use of space in therapy; three (23%) use the technique of role playing; others felt they continued to be innovative and more aware of the non-verbal message/interactions.

Responding to the question, "Do you perceive yourself, now, as having more expertise in the field of alcoholism?" five (38%) said "yes" (one qualified this by saying "just a little") Seven (54%) responded "no" and justified this by statements such as: "did not learn very much about alcoholism," "still, as before, consider alcoholism a symptom", "have more awareness of alcoholism but not more expertise." It is interesting to point out that at least one of the trainees said that although she did not think she learned much about alcoholism, her experience was that with the use of some new knowledge she now works better with alcohol related clientele; other trainees implied having similar experiences.

Seven (54%) trainees thought they now recognize problems with alcohol more easily than before the training; two (15%) said "no": two (15%) did not know; and one (8%) could now distinguish levels of the problem; one trainee (8%) felt she never had any difficulty in recognizing alcohol problems and therefore experienced no change.

Six (46%) of these trainees thought they do or would treat alcohol related cases differently from other clients - most of this difference focused on being more direct about or giving more rapid recognition to the alcohol problem and/or referring to AA. Six (46%) respondents stated they do not treat alcohol clientele differently from others and one (8%) did not know.

5. Final Follow-Up Interview

Approximately a year past their training individual interviews were conducted and Tr. I had an opportunity to evaluate their experience of the intervention once again.

At this time the majority of trainees (54%) mentioned more effective work with families; two (15%) mentioned better understanding of non-verbal techniques; mentioned once each were "better understanding of relationship between family and alcoholism," "better understanding of AA," "personal benefits," "feeling more free in doing therapy." Two trainees (15%) felt that the effects of training had dissipated and/or they were not aware of any skills they now have as a consequence of the training.

In response to which skills were learned and used most frequently, nine trainees (53%) reported that the "action techniques" were the most valuable and more frequently used by them. Other skills mentioned once each were: more comfort in physical contact with clients, new ways of looking at families; being a more dedicated therapist. Alcoholism was not mentioned by any of these trainees, except one who pointed out specifically that training had not resulted in any increase of knowledge

about alcoholism. Only four trainees (31%) felt at the time of this third interview that they had more expertise in alcoholism as a consequence of training. At the same time, six trainees (46%) claimed they could now recognize an alcohol related problem better; five (38%) did not think they could on the basis of the program recognize the alcohol problem better, however, four of the five added that they always could recognize the alcohol problems in clients.

A sense of apparent contradiction in some of the trainees' views is somewhat clarified by one trainee who said: "At first I thought it [training] had mostly impact on my work with families, family therapy. But as time goes on I am realizing I got more in alcoholism than I thought I did." Another trainee pointed out: "I have a much more real appreciation of what happens in a family where there's alcoholism and I try to get more family support." Other trainees did not seem to be quite as aware of the intervention's impact on their work with alcohol related cases, though the data from A-O and CL questionnaires seemed to indicate that there were definite changes among these trainees.

Some trainees, after the training, appeared not to perceive changes in themselves within the context of alcoholism because they saw themselves as having had a positive attitude and worked well with alcohol problems before they entered the program.

The overall attitude communicated through these interviews indicated that Tr. I maintained an enthusiastic and positive view of their training experience, e.g., "I think it was fantastic!" "It was stimulating!" It appeared that although they were not always aware of how the training effected their work with alcohol problemed clients, they had a sense of greater competence and comfort in their role as therapists and that attitude had a direct and productive effect on their work with alcohol problems.

B. Trainees II

1. Time 1.

At this time, the caseworkers who were to volunteer for the second round of training had not yet been identified as a group. They became an identified group at the time of their enrollment in the training program, approximately one year after the first round of questionnaires had been mailed. The A-O and CL data from t. 1., however, enabled the evaluators to use this group as a control.

The average age of those workers who eventually were identified as Trainees II (Tr. II) was 31 years; they had their MSW degree for an average of 8 years and had been employed at their current agency for an average of 5.3 years.

Table 21 summarizes some of the basic data collected from Tr. II at t. 1 in the context of Tr. I and the remaining workers.

Table 21

Summary of Attitude and Caseload Information for Population, Time 1.

Staff	N	A-0				CL			
		Score	Expected Success			No. of cases	%a.r.cl.	dr/pr. clients	
			%a.r.cl.	%g.cl.	d.s.			Total cl.	a.r.cl
CW - (I&I)	70	45.3	34.3	63.5	29.2	28	10.7%	5.0%	48.9%
Tr. I	15	40.0	31.5	63.1	31.6	21	16.7	4.7%	28.3%
Tr. II	17	48.6	39.2	58.2	19.0	24	10.7	4.2%	39.5%
Total	102	45.0	34.6	62.5	27.9	26	11.4	4.9%	42.7%

The mean A-0 score for Tr. II at t. 1 was 48.6, indicating a more positive attitude toward alcohol and alcoholism than either Tr. I (X-0=40) or all other caseworkers from the participating agencies.

Tr. II estimates of expected success with their alcoholic clients again indicates dissimilarity from other caseworkers and from Tr. I, i.e., Tr. II expected to be successful with 39.2% of alcohol related cases; the corresponding expectations were 31.5% for Tr. I and 34.3% for non-trainees. The discrepancy scores (ds) can be considered another index of dissimilarity of

Tr. II. from Tr. I and other workers, i.e., ds's of Tr. I and non-trainees are more similar, 31.6 and 29.2, than the ds of Tr. II, 19.0. Thus, not only did Tr. II have higher expectations of success with alcoholic clients, they also seemed to view them as more like general clients than did either Tr. I or the non-trainees.

Additional differences between Trainees I and II are apparent upon examination of the caseload profile. At t. 1 Tr. II carried a higher average number of clients, i.e., 24 as compared to Tr. I average caseload of 21. However, Tr. II carried on the average a smaller proportion of alcohol related cases, i.e., 10.7% compared to the 16.7% carried by Tr. I. In 39.5% of the alcohol related cases carried by Tr. II, the primary client was the individual with the drinking problem, while Tr. I treated only 28.3% of the alcohol problemed people directly. In terms of experience with alcohol related clientele, Tr. II reported they were significantly more satisfied with their work in this context than were Tr. I, i.e., where as Tr. II were satisfied with their progress in 86.5% of the alcohol related cases, Tr. I were satisfied with progress in only 58.5% of their cases (Table 22).

Table 22

Responses by Trainees to Self-Assessment of Treatment Progress with Alcohol Related Clients, Time I.

Staff	Progress		
	Satisfactory	Unsatisfactory	Totals
Tr. I	31[a]. 58.5%[b].	22 41.5%	53 100%
Tr. II	45 86.5%	7 13.5%	52 100%
Totals	76 72.4%	29 27.6%	105 100%

a. Number of cases
b. Percent of row totals.

$X^2 = 10.44$ df=1 $P < .01$

Table 23 compares ratings of progress between Tr. II and those workers who did not become trainees.

Table 23

Responses by Tr. II to Self-Assessment of Treatment Progress With Alcohol Related Clients, Time I.

Staff	Progress		
	Satisfactory	Unsatisfactory	Totals
CW-(I&II)	154 78.1%	43 21.9%	197 100%
Tr. II	45 86.5%	7 13.5%	52 100%
Totals	199 80%	50 20%	249 100%

$X^2 = 1.75$ df=1 $P > .10$

Although Tr. II reported greater satisfaction in their progress with alcohol related clients than all other caseworkers, the difference is not statistically significant.

On the basis of the data we might expect that at t. 1. workers who were to become Tr. II had less reason to be motivated for a training program in alcoholism than Tr. I. The data directly speaking to the issue of motivation collected from responses to the question "Indicate your motivation for participation in the UCS training program",[1] indicates that although the difference is not dramatic, Tr. II (3.5) did have a lower motivation for this training than did Tr. I (1.9). Non-trainees had the lowest motivation (3.2)[2].

2. Time 2.

At Time 2. Tr. II were still unidentified as a group, i.e., the training program's second round had not begun.

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1. A-O questionnaire, Part 1, #7.

2. The scale was based on values of 1 for Very High Motivation through Neutral to 5 for Very Low Motivation, i.e., 1= Very High, 2= High, 3= Neutral, 4= Low, 5= Very Low.

Table 24

Summary of Attitude and Caseload Information for Tr. II, Times 1 and 2.

		A-O				CL			
			Expected Success					dr/pr cl.	
Time	N	score	%a.r.cl.	%g.cl.	d.s.	No. of cases	%a.r.cl.	Total cl.	a.r.cl.
1.	17	48.6	39.2	58.2	19.0%	24	10.7	4.2%	39.5%
2.	22	46.0	33.9	65.7	31.8%	29	9.2	4.1%	44.8%

The minor amount of change in the A-O scores (-2.6 points) indicates that at this point in time the attitudes and opinions of the trainees to be had not been substantially effected by the first phase of the intervention. During this same time period, the average A-O score of Tr. I, who had completed their training, increased from 40.0 to 56.3, a difference of 16.3 points. The expected rate of success of Tr. II in working with alcohol related clients had diminished, i.e., Tr. II at this time decreased their expectations of success with alcoholic cases from 39.2% to 33.9%, a difference of -5.3%. Note, however, the substantial rise in the ds score (12.8%), an index of increased pessimism toward the alcoholic clients in their caseload. Tr. I expected success rates with alcohol cases during this period increased from 31.5% at t. 1 to 47.7% at t. 2, an increase of 16.2%, and their ds score decreased 12.6%.

The caseload profile of Tr. II suggests a trend similar to that reflected in their A-O scores and rate of expected success data. Although the general caseload average of the group increased from 24 to 29 the mean proportion of alcohol related cases had decreased from 10.7% to 9.2%.

Not surprisingly, however, as they seemed to be experiencing more difficulty with alcoholic clients, Tr. II motivation for training was on the increase i.e., from 2.5 at t. 1 to 2.0 at t. 2.

The table below provides the opportunity to view the basic data fro Tr. II in the context of Tr. I and the remaining workers.

Table 25

Summary of Attitude and Caseload Information
For All Staff, Time 2.

Staff	A-O					CL			
	N	Score	Expected Success			No. of cases	%a.r.cl.	dr/pr. cl.	
			%a.r.cl.	%g.cl.	d.s.			Tot cl.	a.r.cl.
CW-(I&II)	73	45.3	41.1	65.8	24.7%	24	9.2	4.5%	49.1%
Tr. I.	14	56.3	47.7	66.7	19.0%	20	21.4	8.9%	41.7%
Tr. II.	22	46.0	33.3	65.7	31.8%	29	9.2	4.1%	44.8%
Totals	109	47.4	40.5	65.9	24.4%	27	10.5%	4.9%	46.6%

3. Recruitment

The recruitment period overlapped t.2. Thirty staff caseworkers from the four participating agencies were eligible to become trainees for the second round of training.

Each participating agency scheduled one or more staff conferences in the months following conclusion of the first round of training. During these conferences, workers who had completed the training, i.e., Tr. I had an opportunity to present the method and content of their training and their understanding of the alcohol problem. In this manner the staffs in each participating agency were familiarized for the second time with the training program. Staff workers who had not participated in the first round of training were eligible to volunteer for the second round of training at the end of this conference. The opportunity to volunteer was made available again during the month preceeding the second round of training.

In all, a total of 27 workers volunteered for the second round of training. However, five of these volunteers withdrew, leaving 22 workers who became the trainees in the second round of training. All 22 trainees completed the training.

Table 16

Trainee Enrollment - Second Training Group

Phases	Agencies				
	FSA	FC&G	Reg. West	Camb.	Total
June - Aug '72 Recruitment Period	9	5	8	1	23
September-end of recruitment	6	4	8	0	18
October - beginning of training	9a.	5a.	8	0	22
March '73 completion of training.	9	5	8	0	22

a. During the month of September, 3 FSA volunteers and 1 FC&G volunteer withdrew. However, just before the training began another 3 FSA and 1 FC&G workers volunteered.

4. Time 3.

At t.3 Tr. II had finished their training and this project's intervention stage terminated.

Table 27

Summary of Attitude and Caseload Information for Tr. II.

Time	N	A-0				CL				AI
		Score	Expected Success			No. of cases	%a.r.cl.	dr/pr. cl.		Score
			%a.r.cl.	%g. cl.	d.s.			Tot cl.	a.r.cl.	
1	17	48.6	39.2	58.2	19.0	24	10.7	4.2	29.5	32.8
2	22	46.0	33.9	65.7	31.8	29	9.2	4.1	44.8	40.3
3	19	55.1	58.0	69.5	11.5	33	8.0	4.2	52.0	39.4

Similar to Tr. I following completion of the training program, Tr. II increased their mean A-0 score. However, the magnitude of increase is somewhat diffesent. Tr. I increased their A-0 score from pre-training to post-training by 16.3 points, whereas Tr. II for their corresponding sequence increased their score by 9.1 points. These changes represent for Tr. I and Tr. II a percentage increase in score of 40.8% and 19.8%, respectively. Thus, the data suggest that with respect to attitude change Tr. II responded to the training program somewhat differently than Tr. I. In

personal interviews six (30%) Tr. II felt their attitude improved a lot, 12 (57%) felt they changed some or little, and three (13%) experienced no change.

Additional documentation of a positive though different rate of change by these two groups, following training, is the data indicating their expected rate of success with alcoholic clients, i.e., upon completion of their respective training programs, Tr. I increased their estimates of success by 16.2% and Tr. II by 24.1%.

Tr. II also increased their AI scores, as did Tr. I, albeit in a different sequence. The results on the alcoholism information questionnaire receive a detailed analysis in section D. of this chapter.

The caseload data for Tr. II indicates that although their caseloads increased an average of 4 clients (14%) between t. 2 and t. 3, their proportion of alcohol related cases decreased by 1.2%. On the other hand these trainees did increase the proportion of alcohol related primary clients who are drinkers from 44.8% to 52.0%, a difference of 7.2%. (This might be attributed to the method by which cases are assigned, i.e., the decision following intake would most likely be to assign the most obvious alcohol related cases to workers who had undergone an alcoholism training program). Tr. I during the comparable time period, however, increased the percentage of alcohol related primary clients who are alcohol abusers from 28.3% to 41.7%, a difference of 13.4%.

Table 28

Summary of Attitude and Caseload Information for Population, Time 3.

Staff	N	A-O				CL			
		Score	Expected Success			No. of cases	%a.r.cl.	dr/pr. cl.	
			%a.r.cl.	%g. cl.	d.s.			Tot. cl.	a.r.cl.
CW-(I&II)	63	49.7	42.6	62.3	19.7	28	9.0	3.7	41.4
Tr. I	12	51.4	51.7	65.8	14.1	22	17.9	8.6	47.9
Tr. II	19	55.1	58.0	69.5	11.0	33	8.0	4.2	52.0
Totals	94	51.0	44.7	62.4	17.7	28	9.7	4.3	44.7

It appears that after their training as before, Tr. II differed from Tr. I on several important variables related to treatment of alcoholism, including measures of attitude and practice. When the soft data available from the personal interviews of the trainees is examined, the differences between the two groups of trainees again focused on motivation factors. Thus, in the individual interviews, the majority (68%) of Tr. II expected the training would expand their experience in family therapy in contrast to Tr. I 24%. Interest in learning about alcoholism appeared secondary and/or less frequently mentioned

(36%) by Tr. II, while the majority of Tr. I (59%) expressed this interest. Other expectations ranged from interest in learning about action techniques in general (14%), to sensitivity-training (9%), to personal growth (5%) and use of self in therapy (5%).

The differences between Tr. II and Tr. I are further manifested by data re self-assessment of satisfactory work with alcohol related clients. Table 29 summarizes the measures of self-assessment regarding the progress of treatment with alcohol related clients for all three time periods.

Table 29

Response to Self-assessment of Satisfactory Work with Alcohol Related Clients by Agency Staffs at Times 1,2,3.

Staff	Proportion Rated Satisfactory Time		
	1	2	3
CW-(I & II)	78%	76%	77%
Tr. I	59%	73%	84%
Tr. II	87%	91%	87%
Totals	76%	79%	81%

The above indicates that Tr. II not only were intially very confident in their work with the alcohol related segments of their caseload, but that their self ratings did not change during the course of the intervention. These results tend to parallel those for the non-trainees caseworkers, i.e., no change. In contrast to Tr. II and non-trainees, however, Tr. I, as noted in a previous section of this paper, progressively improved their self ratings during the course of the project.

Again, data from personal interviews suggests an interpretation of Tr. II lack of change in self-assessment of progress. Those trainees, who volunteered for the training expecting to learn primarily about family therapy, felt quite pleased at the end of the training and thought that the training lived up to their expectations. On the other hand for those trainees who expected to learn primarily about treatment of alcoholism, the training did not meet their expectations. They felt that alcoholism was not adequately integrated into the experiential and family therapy seminars and/or that there was not enough alcoholism content in general.

In spite of the apparent dissatisfaction among some trainees, the majority of Tr. II (59%) felt that after training they could recognize an alcohol related problem more easily than before. Five (23%) Tr. II responded that they experienced no difference in their abilities to recognize an alcohol related problem and the remaining 18% were non-committal.

Furthermore, fifteen (68%) Tr. II perceived themselves at this time, as a consequence of training, as treating alcohol related cases differently from other clientele; seven (32%) thought they are more confronting with alcohol related clientele; three (14%) thought they used community resources more often with alcohol related clientele; three (14%) thought they "zeroed-in" on behavior, i.e., drinking, more than with clientele presenting different symptom pictures; one (5%) used more medical back up; one (5%) used a more educational/concrete approach; one (5%) was more family oriented. Others did not know, did not have any alcohol cases or expressed confusion regarding the issue. Thus, it appeared that although the training did not live up to some of the trainees' expectations, many trainees did experience changes in the ways they treated alcohol related cases.

Interestingly, the impact of training on treatment of alcohol related cases became more overt as time passed on. When Tr. II were interviewed the second time [4], approximately seven months after they had finished the training program,

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4. Due to changes in jobs, only 19 of the original 22 trainees were employed in the agencies and available for interviews at this time.

alcoholism was mentioned more frequently in their response than it had been the case previously. Thus, responding to question, "Now, a half year later as you look back at the training program, what do you think are the most significant skills you have gained from it?", these trainees mentioned the ability to confront an alcohol related client and action techniques most frequently, i.e., six times (32%) each; being tuned into the signs of alcoholism and awareness of family dynamics were mentioned four times (21%) each; having become a more competent clinician and being more comfortable in working with families were mentioned two times (11%) each; other skills learned as a result of the training program were referred to one time (6%) each, i.e., understanding of alcoholism in the family, improved interview skills, familiarization with some new diagnostic/clinical approaches, greater ease with alcoholic clients, willingness to insist on the alcoholic spouses' participation in therapy; only one trainee said she did not know whether she got any skills at all. Most

Tr. 11, however, remembered the training positively and felt it was well worth the time and energy they had devoted to it.

Further, fourteen (74%) of the trainees felt that they were either more confident and comfortable or more expert in dealing with alcohol realted cases. Four (21%) of the trainees at the time of the second interview did not feel any more expert in the treatment of alcoholism than they did before the training, and one did not know.

When these worker's were asked whether they treat an alcohol related case any differently from other cases, five (26%) did not think so and four (21%) trainees, however, did feel that they treat alcohol cases somewhat differently. Three (16%) thought they tend to focus on the symptom, i.e., drinking, much more; three (16%) thought they are more direct and confronting when working with alcohol cases, two (11%) observed that they are more likely to look for more factual information with these cases.

Finally, although we have no A-O score data for these trainees at the time of the second round of individual interviews, 13 (68%) evaluated their attitudes toward alcohol related clientele as having been improved as consequence of the training;

five (26%) of these workers felt their attitudes were unchanged; and one (5%) did not know.

In summary Tr. II differed on some variables from both Tr. I and non-trainees. As a group they had a more positive attitude towards alcohol and alcoholism, were more confident in their abilities to treat alcoholic persons, and were more satisfied with the progress of their work involving alcohol related clients. The training program had an impact on Tr. II in a pattern similar to that for Tr. I, though the magnitude of change was different. Tr. II increased their A-O scores, increased their confidence in themselves as a treating agent for alcoholic person, and though their proportion of alcohol realted cases decreased, the proportion of drinkers in active treatment increased. Overall, Tr. II were pleased with their experience in the training program and reported having enhanced their skills in dealing with alcoholic persons and their families.

C. Estimated Rates of Success in Treatment of Clients.

This section summarizes data reported in earlier sections of this chapter.

Table 30

Discrepancy Scores (ds) Between Estimated Rates of Success

Staff	Time			
	1	2	3	1 - 3
CW-(I&II)	29.2%	24.7%	19.5%	9.7%
Tr. I.	31.6%	19.0%	14.1%	17.5%
Tr. II.	19.0%	31.8%	11.5%	7.5%

Tr. I, over the length of the project, demonstrated the most extensive change in the way they viewed themselves as treatment agents working with alcoholic clients. Tr. II appear to be only slightly differentiated from the population of non-trainees in amount of change from t. 1 to t. 3 on this measure. However, the magnitude of the increase in estimated rate of success in the treatment of alcoholic clients

from t. 1 to t. 3 for Tr. II (18.8%) is comparable to the increase for Tr. I (20.2%).[5] The ds difference between the two groups of trainees is attributable to the substantial (11.3%) rise in the estimated rate of success in working with the general caseload by Tr. II compared to only a 2.7% rise by Tr. I.

The trainees are further differentiated from non-trainees by the magnitude of the change in their estimated rate of success in working with alcoholic clients. Trainees, as a group, increased their estimates of success 20% from t. 1 to t.3 (35.2% - 55.2%), while these estimates for other caseworkers in the same time frame were increased by only 5.7%, (34.3% - 40.0%). Even when the later figure is corrected by deleting the data of workers added between times 2 and 3, the revised difference (6.5%) is not significant.

During the project's length, staff members increased their average estimates of success in working with alcoholic clients. In addition, the three identified sub-populations showed a steady trend, with the single exception of Tr. II at t. 2, of closing the gap between estimates of success with alcoholic clients and estimates of success with general clients.

Thus, not only is there a measured change to support the positive impact of the training program on trainee's, i.e., they view working with alcohol related cases more optimistically, but there is the suggestion that there was a positive impact on the non-trainee sub-population as well.

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5. Data for this statement is contained on Section B of this chapter.

D. Alcoholism Information Questionnaire

The original design proposed that the information questionnaire measuring trainees' knowledge about alcoholism be developed on the basis of questions submitted to the research team by each of the lecturers on his/her topic of preesentation at the training program. However, due to the failure on the part of the majority of lecturers to deliver the requested questions, the questionnaire was only partially constructed according to the original design; the instrument was supplemented by questions based on a search of alcohol related literature pertinent to each lecture title.

Two parallel forms (Form L and Form H) of the AI was administered to the trainees; in a random order on the first administration and in counterbalanced order immediately after training. A third administration of this test combined the two parallel forms into one single questionnaire (Form BK) and was administered 6-7 months after training.

Due to a substantial change in the format of the first year's lecture series on which the questionnaire items had been based, AI items only partially related to the content of the lecture/seminar sessions were integrated into the second round of training. For purposes of comparison, however, the questionnaire originally designed was administered to the second group of trainees, i.e., Tr. II.

In this context it might be assumed that although there were changes in the content of the training program, the program in itself was not the only source of knowledge for Tr. I & II about alcoholism. On the contrary, it could be hypothesized that if the training program was effective, it would stimulate trainees' curiosity and motivation for further learning about alcoholism. Such effects would be most visible at the time of the third administration, and would reflect trainees' increase in knowledge generated by continuing education.

Table 31 summarizes the trainees' scores on the information questionnaire for the first, second and third administrations.

Table 31

Summary of AI Scores By Trainee Group

Time	Trainee Group						t tests	
	Trainees I			Trainees II			Tr. I vs. Tr. II	
	N	X	SD	N	X	SD	t	p
1st Administration (Forms H & L)	17	38.1	6.6	22	32.8	6.9	2.37	*<.05
2nd Administration (Forms H & L)	14	38.3	6.1	22	40.3	10.3	-.70	>.40
3rd Administration (Form BK)	13	42.6	4.2	19	39.4	3.7	2.04	*<.05

The data contained in Table 31 indicates that the two training groups initially differed from one another with respect to their measured levels of information about alcohol and alcoholism. Tr. I scored significantly higher than Tr. II prior to the start of their respective training sequences. They also scored higher six months after the conclusion of their training, i.e., 2nd administration. It is only at that point in time, at the conclusion of the respective training program, that the two groups are statistically not different.

It appears that for Tr. I, the only measured gain in knowledge about alcoholism occurred during the 6 months after the completion of their training period. The lack of any measured change in the information questionnaire scores immediately after the training might be indicative of the inadequacy of the lecture series. In fact when Tr. I were interviewed it was precisely this aspect of training about which they voiced the most negative criticism, e.g., lectures were "repetitive", "too elementary", "not integrated", "un-original", "uninvolving" and a "wasteful use of time". However, other aspects of the training and other interventions apparently motivated these trainees to continue to learn about alcoholism in the period after completion of training.

Tr. II on the other hand made their gain in measured knowledge about alcoholism during the training period. This might indicate that the modified seminar series was more instructive and involving than the lecture series introduced to Tr. I.

Subsequent to the training period, Tr. II did not appear to have continued their learning about alcoholism.

Table 32 summarizes the amount of information score change that occurred between the first and third measures for each group of trainees. Each group of trainees increased its score, as expected, and the increases were statistically significant. The amount of increase for Tr. I did not significantly differ from the amount of increase for Tr. II.

Table 32

Change in Information Questionnaire Scores Between Time 1 and Time 3

Trainee Group	$\bar{D}$	SD	t	p
Tr. I	3.8	1.22	3.11	*<.005
Tr. II	6.8	1.68	4.05	*<.001
Trainees I vs. II	3.0	2.27	-1.32	>.10

Inasmuch as the forms of the AI are closely related, especially Form BK (3rd administration) which is a composite of Forms H and L, the possibility that the significant increases

recorded may be attributable to practice effects must be considered. A closer inspection of Table 31, Summary of AI Scores by Trainee Group, reveals information that speaks directly to the practice effect issue.

If a practice effect phenomenon was present on the second administration of the questionnaire, it would be expected to occur in both groups equally. Clearly, the average score of Tr. I did not change while the average score of Tr. II changed substantially. Inasmuch as Form BK is a composite of the two forms administered earlier, any practice effect present would show most clearly in this set of scores. However, the record indicates that Tr. I made their significant gain on this administration while Tr. II did not change. This further supports the suggestion, discussed in a previous paragraph, that the training program's formal treatment of alcohol and alcoholism information had a differential impact on the two training groups.

The gains in information scores, though statistically significant, may not appear to be very substantial. In part this appears to be a function of test construction. The range of scores in Table 33 tends to indicate an asymptotic effect in the mid 40 area,[6] thus, suggesting that the test had a "functional ceiling" which was too low and therefore did not allow gains in information to be fully measured.

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6. The highest possible score on the Information Questionnaire is 57.

Table 33

Range of Obtained Scores on The Information Questionnaire

Administration	Trainee Group	
	I	II
1st	21 - 47	20 - 44
2nd	22 - 46	29 - 51
3rd	31 - 48	29 - 46

Additional support for the existence of a low "functional ceiling" on the test is provided by examination of the changes in test performance from t. 1 to t. 3 between two groups divided at the median on the basis of original test scores. Sixteen trainees scored 35 and below; the remaining sixteen scored over 35. The average changes in score for these two groups are summarized in Table 34.

Table 34

Changes in Information Score for Trainee Groups on Basis of Initial Score

Trainee Group	N	Difference Scores	
		ΣD	$\bar{D}$
Below Median	14	150.2	10.4
Above Median	16	28.6	1.8
Totals	32	178.8	5.6

Clearly, the average gain for those trainees scoring below the median on the initial testing is substantially larger than the average gain of trainees scoring above the median. Thus, it is reasonable to assume that the gains recorded in information about alcohol and alcohol abuse are conservative estimates.

Chapter 8

ANALYSIS OF AGENCIES PRACTICE

A. Casework Practice

Data for measuring the impact of the project's intervention on the practice of the casework staff was collected by means of three (3) repeated administrations of the Caseload Questionnaire (CL). Thus, caseloads at three (3) distinct points in time were available for examination. Many variables were singled out for analysis from the data contained in the CL. In this section three variables will be considered, i.e., number of cases, number of alcohol related clients, and number of "problem drinker" primary clients.

In an effort to make the best use of repeated measures, the data discussed below were drawn only from caseloads of those workers who were employed in the agencies throughout the entire project period, i.e., t. 1 through t. 3.

The data from the two trainee groups and the remaining workers, who served as a control group, are presented in the form of mean proportions of the total caseload by category. Also included is the amount of mean change in percent from t. 1 to t. 3. The difference (t.3-1), expressed as percents, are

an index of change and allow for easier comparisons between groups.

Table 35

Summary of Caseload Proportions for All Workers, T.1,2, 3.

Categories	Staff								
	CW-(I & II)			Tr. I			Tr. II		
	t.1	t.3	t.3-1	t.1	t.3	t.3-1	t.1	t.3	t.3-1
% of Total Caseload	59.1	52.5	-6.6	13.5	12.1	-1.4	27.5	33.6	5.1
% of alcohol rel. clients	54.8	51.0	-3.8	19.3	21.7	2.4	25.9	27.3	1.4
% of alcohol rel. clients who are problem drinkers	65.9	46.0	-19.9	13.2	21.8	8.6	20.9	32.2	11.3

Inspection of Table 35 reveals that between t. 1 and t.3, the most substantial change in caseload characteristics was in the proportion of problem drinkers actively engaged in treatment. While the control group, i.e., CW - (I & II), showed a marked decrease in the proportion of problem drinkers being treated, both training groups registered an increase in this category. In addition both training groups recorded increases

in their shares of the alcohol related cases in contrast to the decrease recorded by the non-trainees.

Based on this data, it would appear that either 1.) the intake workers were assigning alcohol related cases more frequently to the trainees, thus, in effect placing the trainees into the category of "alcohol specialists", i.e., that selective assignment was operating ; or 2.) that trainees were more able and willing to recognize the alcohol problemed clients, i.e., that heightened recognition was operating. The CL data indicated that both "selective assignment" and "heightened recognition" were operating simultaneously.

1. Selective Assignment

(a) The view that the trainees were regarded as "alcoholism specialists" is supported by the following data:

At t. 1, while sharing 41% of the caseload, the trainees were treating only 34.1% of the problem drinkers directly; at t.3 the trainees were carrying 45.7% of the caseload and were treating 54% of the problem drinkers directly.

Since this project's data on caseworker's experience with alcoholic and other alcohol related clients focus on the problem drinker as being more difficult to treat than his/her family member, it appears that the dramatic shift in

in the distr bution of the problem drinkers indicated that the trainees were assigned disporportionally more of the difficult alcohol realted cases at t.3 compared to t.1.

(b) Further examination of CL data shed more light on this apperent shift in assignments.

An index of severity of disorder was calculated on the basis of a measure, developed by Mayer and Myerson (1971), of Personal Stability, i.e., "ability to function on a personal level". Mayer and Myerson divided the range of scores for this measure, based on a combination of factors including marital status, employment, age and physical condition, into High Stability and Low Stability. High Stability was found to relate directly to drinking improvement and Low Stability was found to be a poor prognosticator of positive change in drinking behavior as a result of outpatient treatment.

The necessary information to calculate Personal Stability Scores was collected on the drinkers involved in each alcohol related case. Personal Stability scores were derived for 91% of the drinkers at t. 1 and 87% of the drinkers at t. 3. Their mean Personal Stability scores for times 1 and 3 are tabled below.

Table 36

Personal Stability Scores of Problem Drinkers

time 1.

Staff	Personal Stability		Totals
	Low	High	
CW-(I & II)	97[a] 54%[b]	84 46%	181 100%
Tr.	45 44%	58 56%	103 100%
Totals	142 50%	142 50%	284 100%

a. Number of cases

b. row percent

$X^2 = 2.60$ df=1 $p > .20$

time 3.

Staff	Personal Stability		Totals
	Low	High	
CW-(I & II)	52 41%	75 69%	127 100%
Trainees	50 59%	35 41%	85 100%
Totals	102	110	212 100%

$X^2 = 6.52$ df=1 $^*p < .05$

The distribution of Personal Stability scores for t.1 and t.3 has changed significantly, indicating that a shift in case assignment occurred between times 1 and 3 resulting in the trainees' carrying, both directly and indirectly, a more difficult to treat group of drinkers than the non-trainees.

(c) The percent changes in the alcohol related and problem drinker as primary client categories assume additional significance when they are considered from the perspective of proportional representativeness.

At the beginning of this project, since there were no identified alcoholism specialists on the staffs, the reasonable assumption was made that cases in which alcohol was a problem would be randomly distributed among the caseworkers. Therefore, each worker's share of the alcohol related caseload would be proportional to his or her share of the total caseload[1].

The extent to which the discrepancy percentage, i.e., amount of difference in percent between proportion of total caseload and proportions of alcohol related clients or problem drinkers who are primary clients (pd/pc) is different from 0 would indicate a lack of random distribution. This data is summarized in Table 37.

1. For example, if a caseworker is seeing 3% of the agency's active cases, it would follow that the worker would also see 3% of the alcohol related cases, and 3% of the problem drinkers who are primary clients.

Table 37

Caseload Discrepancy Percentages,
Time 1 and 3.

Categories	Staff					
	CW-(I & II)		Trainees I		Trainees II	
	t. 1	t.3	t.1	t.3	t.1	t.3
% Alcohol Related	-4.3	-1.5	5.8	9.6	-1.6	-6.3
% pd/pc	6.8	-6.5	-0.3	8.6	-6.6	-1.4

It is evident from the above table that the largest gains in the predicted direction were made by Tr. I and they had a positive increase in their discrepancy percentages in both categories.

The data also indicates that while the non-trainees moved closer to assuming their share of the alcohol related caseload, Tr. II disporportionally decreased their share of alcohol related cases. However, when the pd/pc category is considered the pattern of change for the non-trainees and Tr. II is reversed, i.e., while non-trainees substantially reduced their share of problem drinkers seen, Tr. II moved closer to assuming their proportional share. The biggest shift in discrepancy percentages occurred in the caseloads

(NOTE: Due to a misnumbering there is no page 112)

of the non-trainees in the pd/pc category. They changed in a negative direction from having more than their proportional share of problem drinkers at t.1 (6.8%) to having less than their proportional share (-6.5%) at t.3, while both trainee groups increased their respective proportions in this category.

(d) An analysis of the presenting problem at intake of alcohol related clients provides still further support for "selective assignment".

The data regarding the presenting problems at intake of alcohol related clients, over the two year length of the project, indicated that the view of the family agencies as a treatment resource, held by these clients, remained fairly stable.

Table 38 shows a breakdown of the major categories of presenting problems over the three periods of time when data was collected.

Table 38

Major Categories of Presenting Problem, Times 1,2,3.

Time	Presenting Problem			
	Marital	Alcohol	Children	Other
1	44%	16%	19%	21%
2	43%	17%	15%	25%
3	38%	16%	14%	32%

A trend, indicating a decrease in the proportion of alcohol related clients presenting their difficulties as those of marriage and child rearing, emerges from this data. The proportion of alcohol related problems does not change. Among the important contributors to the proportion of "other" problems are those which can be classified as intrapsychic, e.g., anxiety, depression.

A similar pattern is displayed in the trainees' data, Table 39, with the exception of alcohol as a presenting symptom. In this category there is a trend toward increasing the proportion, which suggests that the trainees are being identified as having particular expertise in treating alcohol related problems and are being assigned an increasing number of these cases.

Table 39

Major Categories of Presenting Problem for Trainees' Cases, Times 1,2,3.

Time	Presenting Problem			
	Marital	Alcohol	Children	Other
1	47%	11%	24%	18%
2	48%	12%	17%	23%
3	39%	15%	17%	29%

In summary the trainees increased their share of: 1) alcohol related caseload; 2) problem drinkers as primary clients; 3) difficult alcohol related cases. These analysis support the observation that the trainees were, during the course of the project, increasingly identified in their agencies as alcoholism specialists.

2. Heightened Recognition

(a) The observations and experiences of the Cincinnati Family Service Agency (Cohen and Krause, 1971) appeared relevant to this study, as they pointed out that:

> "In many cases the women never mentioned her husband's alcoholism at the time of application for help unless the intake workers asked the right questions (p.14)." As workers became more experienced in the treatment of alcohol related clients... "they discovered that clients often gave clues which could lead to a correct diagnosis if followed up with certain kinds of questions (p.15)."

On the basis of the Cincinnati Study it was expected that this project's training program would also equip the trainees with increased knowledge and skills related to recognition of problematic alcohol use even in the absence of obvious and blatent clues.

A comparative analysis of the mention of alcohol and drinking as an issue at intake and the relationship to the cases' subsequent identification as "alcohol related"

is pertinent to the exploration of heightened recognition.

Of the cases identified as alcohol related by workers at t.1, only 16% specified problems with alcohol as a presenting complaint, although drinking was mentioned at intake in 78% of cases later identified as alcohol related. Thus, in terms of identification of alcohol as a factor in the client's difficulties a total of 22% of the alcohol related cases were subsequently identified without a specific mention of alcohol or drinking at intake. This proportion increased to 24% and 25% at t.2, and t.3, respectively.

Although the data is unclear with regard to whether this declining trend in recognition of an alcohol problem at intake is due to an increased capacity of recognition on the part of workers or reduced levels of recognition by intake workers, it is important to note however, that no worker whose primary activity was intake volunteered for the training program.

(b) A stronger index of the intervention's effectiveness in heightened recognition is the differential between the proportion of cases eventually identified as alcohol related by trainees and non-trainees when alcohol was not mentioned as an issue at intake. This information is summarized in Tables 40 and 41.

Table 40

Proportion of Alcohol Related Cases in Which Drinking Was Not Mentioned as a Problem at Intake.

Staff	Time		
	1	2	3
CW - (I & II)	23%	24%	23%
Trainees	20%	22%	28%

The proportion of cases considered by workers as alcohol related in which drinking as a problem was not mentioned at intake did not change for the non-trainees. At the same time, there was a trend toward increasing skill in recognition of alcohol problems by trainees.

Table 41

Proportion of Trainees' Alcohol Related Cases in Which Drinking Was Not Mentioned as a Problem at Intake, Times 1,2,and 3.

Trainees	Time		
	1	2	3
Tr. I	25%	22%	22%
Tr. II	15%	21%	32%

The data in Table 41 reveals that while Tr. I did not seem to change in their recognition skills, Tr. II demonstrated a clear trend of increasing recogntion.

(c) Data from the final individual interviews lends support to the above stated observation. In response to the question, "Do you find that as a consequence of this training program you can recognize a client with an alcohol problem more easily than before?", 74% of Tr. II responded in the affirmative in contrast to the 46% of Tr. I.

Since the instruction in the recognition of alcoholism was introduced most specifically in the didactic portion of training, Tr. II substantial increase in previously identified cases from t.2, (21%) to t.3 (32%) suggests that the increased integration of alcohol content into both the experiential and didactic portions of the second round of training, described in Chapter 5, had an important impact on effects of training.

In summary it appears that Tr. II improved their skill in recognizing alcohol related problems in the absence of obvious and blatent clues, while Tr. I and non-trainees did not show a similar change. The improved skill of Tr. II is attributed to the greater integration of alcohol content in the second round of training.

B. Agency Caseloads

1. Homogeneity of Agency Practices.

The four agencies which participated in this project differed on a number of important variables, such as size of staff and number of locations. However variables relevant to this study are those which relate directly to the delivery of services to alcohol related clientele. Thus, prior to the pooling of caseload data of the four family agencies the issue of homogeneity among agencies was examined, i.e., were the agency practices sufficiently similar to justify treating the data as coming from a single population.

The distribution of non-alcohol related and alcohol related cases by agency for times 1, 2 and 3 were statistically analyzed to test for significant differences between agencies (Table 42).

Table 42

Distribution of Non-alcohol and Alcohol Related Cases by Agency

Time 1

	Agencies				
Cases	FSA	FC&G	Reg.W.	Camb.	Totals
Non-Alcohol related	1088	813	367	111	2375
Alcohol related	138	114	42	13	307
Totals	1226	927	409	124	2686

$X^2 = 1.40$ df=3 $P > .30$

Time 2

Cases	Agencies				
	FSA	FC&G	Reg.W.	Camb.	Totals
Non-Alcohol related	975	962	389	56	2382
Alcohol related	124	109	36	10	279
Totals	1099	1071	425	66	2661

$X^2=4.33$ df=3 $p>.20$

Time 3

Cases	Agencies				
	FSA	FC&G	Reg. W.	Camb.	Totals
Non-Alcohol related	1015	983	317	60	2375
Alcohol related	110	104	33	8	255
Totals	1125	1087	350	68	2630

$X^2= 2.13$ df=3 $p>.30$

As the tables above indicate, at each point in time, the X^2 value does not approach statistical significance. Therefore, it is reasonable to conclude that on this measure the agency practices are sufficiently similar to justify the pooling of caseload data and treating this data as emerging from a single population.

2. Summary of Attitude and Caseloads of Participating Agencies' Staffs.

A summary of information on attitudes and caseload for all staff who completed questionnaires at each data collection point is contained in Table 43. The return rate for the A-0 questionnaire ranged from 88% to 94%; the return rate for the CL questionnaire ranged from 78% to 91%.[2]

Table 43

Attitude and Practice Data for Total Staff

	A-0					CL				
			Expected Success						dr/pr. cl.	
Time	N	Score	%a.r.cl.	%g.cl.	d.s.	N	No.of cases	%a.r.cl.	Tot.cl.	a.r.cl.
1	113	45.0	34.6	62.5	27.9	102	26	11.4	4.9	42.7
2	113	47.4	40.5	65.9	25.4	109	24	10.5	4.9	46.6
3	105	51.0	45.6	62.4	16.8	94	28	9.7	4.3	44.7

The data indicates that over the project's length, the agencies as a group improved alcoholism related attitudes and their view of adequacy in treating the alcoholic client. However, there

2. The staffs were requested to complete the A-0 questionnaire on their own time, in an effort to alleviate the burden on agency time, and received a token compensation of $3.00 upon return of the completed questionnaire. The CL questionnaire was completed on agency time.

was a steady decrease in the proportion of alcohol related cases and only a slight increase in the proportion of drinkers in direct treatment among the alcohol related cases.

More detailed analyses of these data are contained in several sections of this report.

3. Client Characteristics.

(a) Length of Cases:

Medians for all caseworkers for times 1,2,3. are 7 months, 6 months and 9 months. This trend of increasing length of time in treatment suggests that the workers were retaining alcohol related cases longer, which is generally viewed as a positive index of treatment effectiveness in cases of alcoholism. The trainees, as a group, closely parallel this trend with the following medians for times 1,2,3; 5 months, 7 months, and 9 months.

(b) Age of Drinkers:

The average ages for all drinkers, receiving both direct and indirect services, for times 1,2,3 respectively, are 45 years, 45 years, and 44 years. The average ages for those drinkers involved in cases carried by the trainees are 46 years, 45 years and 42 years.

The average age for all primary clients who are drinkers decreased from 44 years at t.1 to 42 years at t.3. The decreasing age trend for the trainees' cases could be interpreted to have resulted from the trainees recognizing alcohol related problems when they are less overt and thus at an earlier point in the disorder's history. However, this trend is somewhat confounded by the trainees being involved in more difficult cases which tends to involve older alcoholic persons.

Thus, the overall data indicates a gradual lowering in age among the alcohol abusers involved in both direct and indirect agency services. While this trend is commendable from the viewpoint of earlier identification, it also reflects a national trend in the average age of alcohol abusers and alcoholics.

(c) Other Selected Characteristics of the Primary Client and the Problem Drinker:

The primary client is in nearly 3 out of 4 cases a female, usually a spouse of the drinker. This is in contrast to the drinker who is male in nearly 4 out of 5 cases. Over the three time periods that data was collected these ratios fluctuated only minimally. In contrast to the national reports of increased alcohol abuse the agencies' caseloads did not indicate a response

to this phenomenon. That is, there were no indications of a larger percent of female alcohol abusers as either primary clients or drinkers associated with alcohol related cases.

Clearly one of the keys to bringing the male alcohol problemed person into active treatment is to have more male therapists.

Bailey(1973) for example has stated that, "It becomes clear that an almost universal theme in the treatment of alcoholic males must be the fostering of appropriate masculine roles. This might be most readily accomplished with a male therapist, although of course women constitute the majority of staff in family casework agencies (p.28)."

In this study only one agency could be considered to have an adequate quantity of male therapists. BC&G had a staff which was approximately 59% male, compared to the 10% to 15% range of the other agencies; BC&G also carried at least twice as many males as primary clients (c.a. 30%) compared to any of the other participating agencies.

In the context of the religious affiliation among the drinker group, more than 75% were Catholic and approximately 20% were Protestant, 1% Jewish and 4% other. This compares to the 1965 census projections for the approximate area served by the agencies of 55%

Catholic, 32% Protestant, 10% Jewish and 3% other. Thus, it appears that among the identified alcohol related clients receiving services in the family agencies, there is a disproportional representation of Catholics compared to the other religious affiliations. These proportions remained quite stable over the project's duration.

An estimate of Social Status of primary clients was based on a two factor (education and occupation) formula developed by Hayer and Myerson (1971). The caseload distribution on social status remained quite stable during the project's length, i.e., 16% Low Status, 56% Middle Status, and 28% High Status. The modal occupational grouping for these clients was skilled employment, and their median and modal level of education was high school graduate.

(d) Sources of Referral:

For t.3, approximately six months after the second round of training had ended, the referral sources for alcohol related cases were examined. The largest category of referrals were self (31%); medical facilities ranked second (21%); spouse and other family members was the third most frequent source (14%). AA and other

categorical (alcohol) agencies accounted for fewer than 3% of the referrals. These data provide rather striking indications that the family agencies are not being regarded by the categorical system as a resource for their clients.

C. Comparison Agency Data

In this section data gathered at t.2 from the caseloads of categorical agencies serving alcoholics on an out-patient basis is summarized and compared with the family agency data. The comparison focusses on the question, "Are the clients with alcohol related problems seen in categorical (alcohol) agencies different from the clients seen in family agencies?"

Two comparison agencies were used: Washingtonian Hospital, best known as a resource for both out-patient and in-patient treatment of alcoholism; and the Alcoholism Clinic of the Peter Bent Brigham Hospital, a special unit in a general hospital setting.

The results of the comparison indicate that one of the most important differences between the categorical and family agencies is in the percentage of drinkers as primary clients.

Although in the comparison agencies the drinker was the primary client in almost 100% of the cases, in family agencies the corresponding figure was 36%. Further, of the drinkers seen in the comparison agencies, 57% reported having received prior treatment for an alcohol related problem, and in the family agencies only 46% of the drinkers who received direct treatment fell into this category. However, approximately 60% of all drinkers involved, both directly and indirectly, in family agency cases had prior histories of treatment related to alcohol.

As could be expected from the composition of primary clients cited above, the categorical agencies' primary clients run between 65% and 70% male compared to the family agencies corresponding figure of 21%. This ratio is reversed for the family agency when the sex of the drinker involved is calculated, i.e., 75% male. The alcoholism agencies are involved with about 70% male drinkers.

The alcohol abuser seen in the alcoholism agencies was on the average somewhat older (48 years) than the comparable client in the family agency (44 years).

While the educational levels of drinkers involved in the two types of agencies appear to be similar, i.e., the median and modal level of education is a high school diploma, the occupational data is quite different, i.e., the modal occupation of the comparable group in the family agencies was "skilled".

A closer look at the proportion of unemployed among the two types of agencies revealed that in alcoholism agencies, 40% of the dinkers were unemployed, whereas in family agencies only 15% were unemployed.

The comparison of marital status of drinkers involved as both direct and indirect clients revealed additional differences. The drinkers in the alcholism agencies were in an unmarried category (12%) slightly more frequently than those in the family agencies (9%), were less often in the married category (46% to 58%) and were more often separated or divorced (37% to 31%).

Thus, in summary it appears that the alcohol abusers, with whom the family agencies were involved, were a younger, less chronic, and more socially intact individuals than those seen in a sample of two categorical agencies. Though the differences between the two types of agency's are not as dramatic as those reported by Bailey (1968), there is support for the view that family agencies (generic agencies) do attract alcohol problemed clients at an earlier stage of the disorder than the agencies in the categorical system.

Chapter 9

ANALYSIS OF IMPACT ON AGENCY LEADERSHIP

A. A-0 Scores of Executive and Supervisory Level Personnel.

It was assumed that senior personnel exert both direct and indirect influence on an agency's policy and practice. Thus, support of the project's objectives by executive and supervisory level personnel was considered an important element in the effectiveness of the intervention. The analysis of the initial (t. 1) A-0 scores for this group of personnel provided an index of the climate in which the project began. Later, these data were used to indicate the impact of the project's intervention on this sub-population.

A total of twenty one (21) executive and supervisory (E&S) level personnel were identified as having been employed in the agencies throughout the duration of the project. Their mean A-0 scores for Times 1 and 3 are summarized along with the respective score for total agency personnel in the table below.

Table 44

Summary of Mean A-O Scores for E & S Personnel
and
All Personnel for T. 1 and T. 3.

Staff	N	Time		
		1	3	3-1
E & S	21	58.3	63.6	5.3
All CW-(E&S)	56	43.8	51.8	8.0
Total	77	47.7	55.0	6.3

Table 43 displays the differences between the average scores of E & S and all other agency personnel. The A-O scores of the agencies' on both the first and third administrations were substantially higher (14.5 and 11.8 points, respectively) than A-O scores of the remaining staff members who were also employed in the agencies throughout the duration of the project. Both subgroups improved their scores during the project's duration. A somewhat confounding effect on the magnitude of change is the influence of trainees in both groups of workers. Among the E & S group, the seven trainees had a mean change of 7.1 points and the remaining 14 senior personnel had a mean change of 4.4 points; similarly, for the remaining workers, the 27 trainees had a mean increase of 10.5 points compared to the 5.7 point increase for non trainees.

Table 45

Mean A-O Scores of Executive and Supervisory Level Personnel by Agency, T.1 and T.3.

Agencies	N	Time		
		1	3	3 - 1
FC&G	4	66.5	67.5	1.0
BFS	11	62.1	67.2	5.1
Reg. W.	6	45.8	54.3	8.5
Totals	21	58.3	63.6	5.3

An extrapolation from the trainees' data reported in a previous section would suggest: a.) an inverse relationship between motivation for the training program and A-O score; b.) a direct relationship between behavioral impact of the intervention and amount of A-O score change. On this basis, Region West would have the highest level of motivation and experience the most impact. FC&G would have the lowest motivation and experience the least impact. BFS measures would fall between the other two agencies on both motivation and impact.

It is apparent that the training program had a differential impact on the trainees' A-O scores at both E & S and staff levels compared to the A-O scores of the non-trainees. However, the

scores for non-trainees did increase during the project's duration, E & S level personnel scored substantially higher on initial administration and maintained this differential through the third administration.

On the basis of attitudes toward alcohol and alcoholism, as measured by the A-O questionnaire, it could be inferred that the E & S level personnel were receptive to an intervention designed to improve practice of the agencies caseworkers in the area of alcoholism. Further, the increase in mean A-O score recorded by this group is an indication that the intervention had an effect on E & S personnel and that this effect was in a positive direction.

An additional breakdown of the A-O scores for E & S by agency in Table 44 suggests some hypotheses which can be explored in the remaining sections of this chapter.

B. Executive's Questionnaire

The Executive Directors of each participating agency were requested to answer in written form a series of questions pertinent to this project. These questions, collected at three different times during the project period, were designed to allow for examination of differences among the agencies' receptivity toward this project and to provide an index of changes, if any, occurred, in the executives' attitudes toward the project's intervention and impact.

Thus, in response to the question: What do you consider to be the maximum goal(s) that can be realistically expected to be accomplished with alcoholic patients through treatment?", some differences in the expectations were expressed at the time of initial administration. While for one executive at least some reduction in abuse of alcohol was sufficient and another stressed improvement in support systems, two of the executives saw "total sobriety" as a realistic goal for these clients. These expectations remained relatively stable over the three periods of measurement; the one exception was in the instance when a new executive director held a somewhat different point of view from his predecessor, i.e., focused more on abstaining and developing family support systems than reduction of drinking behavior and containment of anxiety.

The executives' view of outcome following treatment was elicited in responses to the question: "From your experience over the past year what tends to happen to alcoholic patients after they have received treatment at your agency?" Again, though somewhat different, the views of the executives did not change very much over the three administrations: they observed that the alcoholic client usually needs continued attention, and support systems, and might from time to time experience recurrence of problem drinking. One executive, however, changed from responding the first time, "I don't know", to pointing out

on the second administration, "They [alcoholics] function adequately in the community", and the third time, "They remain abstainers." This executive, during the second and third administrations appeared to have been much more certain of the treatment results achieved at his agency than were the other executives. Such certainty tends to imply that this executive experienced less need for the intervention offered by this project than did other executives.

Responding to the question, "In your opinion, how will (did) the alcoholics and their families served at your agency benefit as a result of the UCS training program?", three executives expressed similar hopes, such as; promoting workers abilities to facilitate social functioning of alcohol related clients, or having workers who have expanded and sharpened skills in dealing with alcohol related problems. During the last interview, the executives thought that, although their alcohol related caseload had not been increased according to their expectations, the trainees were capable of working with alcohol cases more comfortably. One executive, however, expressed much more skepticism as he pointed out: initially, "It remains to be seen," on second questionnaire; "I don't know how," and on third round; "I don't know." On this question, as on the other questions, it was the same executive who differed. Finally, in reviewing on the last questionnaire, "How did the agency benefit from the train-

ing program?", the tone of the responses seemed quite positive. The executives noted a range of benefits including: "more awareness of alcoholic person and family," "some workers learned more about issues in alcoholism," "stimulated leadership and activity in community for providing services to alcoholic persons," "some workers added skills which can be used with other clients," The executive who was most divergent from the other's, however, only specified that: "Some workers learned about incidence, etiology, etc. of alcoholism in theoretical presentations."

Thus, it appeared on the basis of responses to this questionnaire that the executives' attitudes toward alcohol related clientele and this project changed only minimally, if at all. Additional data regarding these attitudes was collected on the basis of individual interviews, and other less formal meetings and conversations with the executives and/or directors of the staff at the agencies.

This data supports the differences in receptivity toward the project and/or the intervention among the agencies. The administrators of Region West agency consistently voiced both support of the project and a positive attitude toward the training. Their energies were concentrated more on how to improve and/or continue the results of training, how to attract more alcohol related clients to the agency and on undertaking

leadership in organizing services to alcoholics within the community. In contrast to this, BFS E & S expressed much more ambivalence. They were disappointed about the lack of direct attention to and/or integration of the alcoholism content into the training. This was expressed by such statements as: "As I expected, family therapy and alcoholism was an artificial marriage.", "In terms of working with alcoholics I don't know", "I'm not sure I see any effects of training." However, these views were also qualified by such statements as: "I see a sense of enthusiasm about effectiveness of the treatment approaches introduced... workers have a greater sense of openness and this reflects itself in their -- throughout their caseload.", "Workers now view the alcoholic as a person, part of the family not someone who is automatically set aside."

At BC&G, E & S expressed greater reservations regarding the training program than their counterparts in the other agencies Again, there as an expressed disquietude regarding the lack of explicit focus on alcoholism, and lack of integration during the training between family therapy and alcoholism. There were also reservations expressed regarding the new techniques introduced by the trainors. On the other hand the trainees at this agency were regarded by their E & S as having achieved important new skills and were better equipped to work with alcohol related cases.

The Cambridge agency administrators after the first round of training were much more concerned about their reorganizational

struggles than about the impact of this project. They did view the training to have been useful for work in general family therapy and with alcohol related clientele.

C. Trainees' Views of Agency Leadership

From the trainees' point of view, the E & S staffs of the agencies were not quite as uniform or consistently positive in their attitudes toward the project and its objectives as they themselves had expressed (Section B, this chapter).

1. Region West

The most unanimous view of the E & S attitudes was voiced by both groups of trainees from Region West. Tr. 1 views of their E & S ranged from: "They are very excited about it" and "They are very positive and welcome this as an experiment", to "They are very positively disposed, but they were surprised when we [trainees] expressed that this is just a beginning -- that we want to follow up this training with more training and experience in treating alcohol problemed families", "That this is just the beginning, not an end."

2. BFS

Tr. 1 from BFS of Boston had a divergent and less positive view of their E & S personnel attitudes toward this project than the Region West trainees. Most of the concern they experienced stemmed from the E & S view that the training was inadequate in

terms of alcoholism input. Thus, Tr. I made comments such as: "The administration seems to think that the project was misrepresented", "They are either negative or ambivalent about the training", "There was a lot of skepticism about this but now [past training] they seem to be much more positive about it", "The program seems to them contradictory to the accepted techniques of working with alcoholic." On the other hand some trainees at this agency felt that the E & S personnel were aware of the importance of this project and/or that they were quite encouraging. Over time the views expressed seemed to be more and more non-commital, i.e., trainees responded by saying more frequently, "I don't know", "It's hard to say", or "not sure."

Tr. II views of E & S attitudes toward the project were similar to those of Tr. I, Region W. Tr. II speaking out on this matter, made statements such as: "They are quite positive -- this administration is not rigid or constricting," "Very positive because they see trainees so enthusiastic." In view of these attitudes it was difficult for the trainees to understand why the agency was not attracting more alcohol related cases and they perceived the same concern among the administrative staff. These perceptions and concerns did not change during the second set of interviews.

Tr. II also had a view of their administration similar to that of Tr. I: "They seem to be supportive but they feel

that alcoholism was just tacked on", "They were glad to offer us another in-service training program. But when the agency experiences financial squeeze they like to see some proof of it [training] working. They were not interested in the family therapy, but in alcoholism training." "The supervisors seem to be somewhat positive -- certainly they are not hostile to the training." One trainee thought "the administration was disappointed that the agency's alcohol caseload had not increased." Thus, most trainees viewed the E & S attitudes towards the project to be generally positive, but with qualifications and further expectations of the benefits to accrue to the agency, and its clients. During the second interview these trainees, as did Tr. I, became more ambiguous in their views: "The agency's attitudes seem to be mixed", "there are some reservations... ", "... no one talks about it", "I don't know". Two trainees however, still viewed the agency's E & S attitudes to be definitely positive.

3. FC&G

Tr. I expressed on the first follow-up interview uncertainty about the E & S attitude toward the project. In subsequent interviews she thought that she had received some "double messages" about the project from the administration.

Tr. II from BC&G did not appear to have a definite view of their E & S attitudes. Most said "I don't know" and qualified this by statements such as: "... They are reluctant to change

or try new things", "... some skepticism about the techniques introduced by the training", "They are annoyed at the way the BFI sold the training." At the time of the second interview these trainees became even more uncertain about attitudes of their E & S staff, i.e., the "I don't know" response was no longer qualified.

D. Agency Level Activity

Each agency tended to respond somewhat differently, corresponding to the views described in the preceeding Section, in terms of policy or activity changes related to the alcohol problem. Region West was clearly the most active agency in assuming a leadership role in the delivery of more adequate services to the alcoholic person in the community. Though this agency had long been interested in the alcohol problem, it appears that the project stimulated a substantially increased level of activity. Staff members were elected to various boards, including half-way house, de-tox centers and area citizen committees, specifically concerned with alcohol problems. Region West convened an area wide meeting of agencies involved in delivering services to alcoholic and alcohol related clients, the first time a family agency assumed such leadership in the Metropolitan Boston region. Despite all this activity, over the project's course the agency's proportion of alcohol related clients decreased. This phenomenon

has been both troubling and perplexing to the agency leadership.

The BFS experience was varied. As the soft data indicated, the administrators were at times very skeptical about the training program. The agency had invested three years of in-service time to a family therapy training program which concluded just a half year before the start of the alcoholism training program. They were concerned that the emphasis of the training would be on family therapy and not alcoholism, as they wished it to be. As the training progressed, some key administrators felt that their fears were justified. Thus, although the agency seemed to be genuinely concerned about the alcohol problems, there were some negative feelings about the focus of training and the training approach.

(NOTE: Due to a misnumbering there is no page 142.)

Furthermore, BFS did undergo major personnel changes at top administrative levels prior to and during the second round of training which may have deflected, temporarily, some momentum that the intervention was developing. During follow-up interviews, some trainees mentioned that staff meeting time they had requested for discussion of alcoholism had not come through; another trainee was unsuccessful in getting referrals of alcoholics for a therapy group he wanted to start; although peer consultation groups were numerous in the agency, alcoholism was not among the topic areas. However, approximately six months after the conclusion of the second round of training, one of the Tr.I was named the in-house alcoholism resource person. This action may be a harbinger of increasing attention to alcohol problems.

BC&G was the only participating agency, during the project period, which specifically mentioned in its publicity releases that it was a resource for problems with alcohol. The focus of this publicity - on the teenage drinker was related to a special program in addictions for which the agency had a special grant. However, the leadership of this agency, in comparison to their counterparts in the other agencies, expressed stronger and more frequent skepticism about the training program. This attitude seemed to be reflected in staff behavior, e.g., the agency had by far the highest number of trainee withdrawals prior to the

start of training, and it was the only agency whose mean A-O score decreased over the project's length. Administrators and trainees from FC&G, which has a strong individual analytic bias in its treatment orientation, felt that the training program did not give sufficient validation to their theoretical approach and make an effort to integrate it with the systems approach and the specialized techniques that were presented. Although a majority of the FC&G Tr. II described having had negative experiences in the program, in contrast the agency's single trainee in the first round became a dynamic recruiter for participation in the second round. She appears to have been informally designated the in-house expert on treatment of alcoholism and is frequently sought out by other staff members for consultation.

Cambridge as noted in an earlier section, was not only different from the other agencies in some of the more important aspects, but it had undergone a somewhat turbulent period during the project's length. Although the agency is located in an area of Cambridge where there is a high density of alcohol abusers, the small staff size did not allow for outreach activity.

During the period of the project, after t.1 and t.2, 25 new staff members were hired by the four agencies. Four (16%) of these new staff reported having had prior specialized training in alcoholism. This was in contrast to the 8% so indicating at t.1. There is inadequate information available to determine if this reflected a change in hiring practices or a change in graduate social work training.

During the second half of this project, the project team worked closely with the Executive Directors and Directors of Professional Services in an effort to develop a fundable proposal in the alcohol abuse and alcoholism area. This activity and its regular meetings helped to keep alcohol problems in the awareness of these personnel and it can be expected that this focus on alcohol problems had an effect on the executives' attitudes, which communicated to the rest of the staff, and influenced the workers' views, attitudes and practices.

PART III

CONCLUSIONS

Chapter 10

DISCUSSION

A. General Effects of Intervention

The results of this project's study indicate that the most consistent and significant impact of the intervention was on the attitudes of workers who were employed in the agencies over the entire length of the project. Although the magnitude of change differed for the three sub-populations, i.e., two sets of trainees and non-trainees, all of them displayed a measured improvement in their attitude toward alcohol, alcoholism and self as a treating agent. It has been suggested that the most dramatic increase, which occured in the first group of trainees was at least partially due to their pre-training experience of discouragement or difficulty in working with alcohol related problems and their consequent high motivation to modify their professional stance vis-a-vis alcohol related clients. Thus, they volunteered for the training program, open to new ways of looking at and dealing with alcohol related clients. Trs. II on the other hand initially (t.1) appeared neither as negative about alcohol, alcoholism or selves as treating agents, nor as highly motivated to improve their views

of and work with alcohol related cl'entele as did Tr. I. This was most apparent in their responses to the first question on the individual interviews which dealt with their expectations of the training, i,e., although among both sets of trainees there were many workers who focussed their expectations on learning about new and more active skills in working with families, 68% of Tr. II had this expectation compared to 41% of Tr. I. Once involved in the training, however, both sets of trainees were aware, despite whatever skills or experiences they were most motivated to get from the training, that: portions of the training were devoted to didactic presentations on alcoholism; the project was supported by the NIAAA funds; a series of questionnaires regarding changes in knowledge about, attitude toward, and practice with alcoho: related clientele had been and/or were scheduled to be administered by the project staff.

It is assumed that these elements of awareness were operating at the time of the workers' decision to volunteer for the training program as well as during and after the training. In a sense we might refer to this contextual matrix as effecting results similar to what is referred to as a "Hawthorne effect."

The determination of the extent to which attitude and practice changes were directly due to the major intervention, a "ripple effect", a "Hawthorne effect", or some combination of these is difficult to parcel out.

At this point, however, an additional complicating factor must be considered, i.e., most workers in the participating agencies were not instrumental in determining the nature of their caseload. In most instances cases were assigned by an intake worker or supervisor following the initial interview. Thus, workers who were known as planning to or those who had participated in the alcoholism training program would more likely be selected as those to whom alcohol related cases might be referred. One supervisor for instance said: "No one likes to have an alcoholic case assigned to them; so now I feel better when I can assign these cases to workers who have participated in this training." In this context Kelman (1974) points out, "Extraneous forces may thus precipitate an action for which the person was already partly prepared. The action in turn contributes to attitude change, in the sense that it provides an occasion for the person to sharpen the new attitude and commit himself to it (p. 321)." Thus, we might hypothesize that merely being in a specific training program, having other co-workers know, and having an array of

auxiliary related activities, i.e., questionnaires, meetings, interviews, did play a major role in influencing attitude change among the trainees. It might even be expected that the confluence of all the variables determining the attitude change might not only increase the magnitude of change, but its endurance and behavioral change correlates as well.

Thus, it was expected that the magnitude of changes in attitude might correlate with the magnitude of changes in practice. That is, Tr. I would increase their alcohol related clientele most dramatically, Tr. II would increase their clientele at a somewhat lower level than Tr. I, and the case-workers not participating in the training would demonstrate the least positive change in their practice with alcohol related clients.

The change among non-trainees was attributed to the affects of indirect intervention, i.e., "ripple effect" and/or to an effect best categorized as a "Hawthorne effect".

B. Effects of Indirect Intervention

The original design of this project called for the training of all workers, including supervisors and administrators, in all agencies over a two year period. When this became unfeasible, primarily due to a 50% reduction in the budget requested, the design was modified. The reduced level of funding allowed for the training of 50% of the agencies' staffs.

It was anticipated that even with the modified design the intervention would still having an impact on the agencies and their staff's similar to the one expected in the original design.

1. The "Ripple Effect"

The mechanism postulated for effecting change in those workers not directly involved in training was the "ripple effect", i.e., that attitude and practice change among trainees would influence the attitude and practice of non-trainees. Just as a pebble dropped in water influences the surrounding environment, the direct intervention with the trainees was expected to effect changes in their surrounding environment, the remaining agency staff.

There are a number of indications that the non-trainees, indeed, experienced changes related to the interventions of this project.

(a) The most apparent change in this group occurred in the A-O scores of those non-trainee staff members employed in the agencies throughout the project's duration. Their scores improved while the scores of non-trainees, who were employed, after the project began, decreased.

(b) An additional change of these non-trainees was in their increased estimates of success in working with alcoholic clients, and the estimates of non-

trainees, who were employed after the project began, increased somewhat less.

(c) Furthermore, there was a positive correlation (+1.0) between the increase in agency mean A-O score and proportion of trainee participation by agency.

(d) Finally, the change in proportion of alcohol related caseload for non-trainees by agency, t.1 to t.3, corresponded to the respective mean agency changes in A-O scores.[1]

The data cited above are consistent with results that could be anticipated from the influence of a "ripple effect". Though the non-trainees in the agencies who were employed throughout the project's duration improved on a number of attitude and performance measures, the magnitude of change was not as great as the change recorded by the trainee groups. Furthermore, the change on the measures by new non-trainees ranked lower than other non-trainees.

In addition two fairly consistent patterns of change have been observed which tend to support a "ripple effect".

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1. For three agencies:

	$\bar{D}$, A-O	$\bar{D}$, Alc. Rel.
Reg. W.	12.0	7.3%
BFS	8.1	-1.0%
BC&G	4.3	-2.1%

(e) On many key measures the amount of positive change is rank ordered from greatest to least as follows:

1. Trainees I
2. Trainees II
3. Non-trainees
4. New non-trainees

Since Trainees I were clearly the group with the most personal investment in and motivation for improving their performance in treating alcohol related clients, it is not surprising that they registered the most gain. The non-trainees registered gains, albeit at a lower magnitude than the trainees, suggesting that the ripples (changes) are less pronounced the further they are from the source (direct intervention).

(f) The amount of "agency" change on some key variables is directly related to the proportion of agency staff participating in the training. This suggests that the larger the pebble (proportion of trainees), the larger the ripples (impact on the non-trainees).

Also supportive of the postulated "ripple effect" is the decrease in attitude scores of staff hired after the project was underway, consistent with the A-O negative practice effect (see Chapter 6), suggesting that they were not influenced by the intervention. These workers were not present in the agencies when

the project was initially announced and presented, therefore most of their acquaintance with the "UCS Alcoholism Project" was based on filling out questionnaires and occasional references by colleagues. Based on the project staff's periodic communication with new workers, there was a distinct impression that they did not fully understand the intervention effort and their role in it, e.g., a number of workers indicated they did not feel part of the evaluation effort, and some occasionally expressed confusion about the project. This was also in view of the trainees' reports that for the most part they communicated only minimally about th training program with their fellow workers, new or old, thus tending to undermine the "ripple effect" since a major channel of influence, i.e., word-of-mouth, was quite reduced.

2. Alternate Perspective

Some results however, appear inconsistent with the data supporting a "ripple effect" and therefore deserved closer examination.

(a) The rank ordered results in which Tr. I out rank Tr. II on most measures of change could be viewed as contradicting the "ripple effect," i.e., Tr. II should have been influenced prior to training by Tr. I and therefore their change

over the project's length should have been equal to or greater than Tr. I. In fact Tr. II A-O scores dropped at t.2, suggesting the influence of a negative practice effect rather than a positive ripple.

(b) The results of change in measures of attitude and practice at BC&G provide an additional contradiction. In examination of these results emphasis is placed on Tr. II since there were five in this group from BC&G in contrast to the agency's single Tr. I. Thus, if a "ripple effect" were operating, it would more likely by the result of Tr. II influence.

Attitude scores for BC&G non-trainees improved over the project's length, while the scores of Tr. II decreased 15 points between t.1 and t.2 and remained unchanged following their participation in the training program. In addition Tr. II porportion of alcohol related caseload, following training, was reduced to almost half of what it had been at both t.1 and t.2. The non-trainees, over the same time period, reduced their proportion of alcohol related caseload to approximately 85% of what it had been.

These data, contradicting positive effects of intervention, might be at least partially due to the interrelationship between the agency's philosophy and that of the training program. The trainees from BC&G appeared somewhat "turned off" by the training program, some felt there was not enough training in alcoholism, others felt their psychoanalytic framework was not recognized and valued by the trainers, and some experienced confusion in how the family approach to alcoholic clients fitted with their more individual orientation. In contrast, the staff member who participated in the first round of training was a strong proponent of the program.

In summary, positive change did occur, primarily attitudinal, among the group of non-trainees who were employed in the agencies throughout the program's length. There is some evidence that this change was directly related to the influence, however subtle, of those workers who directly participated in the major intervention. Detailed examination of the data exposed sufficient inconsistencies to suggest a supplementary explanation of the changes recorded by non-trainees, i.e., a "Hawthorne effect". That is, some of the changes can be attributed to the non-trainees' increased awareness of alcoholism which was generated

by the knowledge that their agency was participating in an alcoholism project and by their repeated contact with the project's several evaluation data instruments.

In contrast to the indirect intervention discussed in this section, trainees were considered to have participated in a direct intervention component of the project and effects of this direct intervention are discussed in the next section.

C. Effects of Direct Intervention

1. Trainees 1.

Compared to their co-workers, Tr. 1 were initially less positively disposed in their attitudes toward alcohol and alcoholism and as a group they were less optimistic about positive outcomes in treating alcohol related cases. At the same time, although having smaller caseloads, they carried disproportionally more alcohol related cases than other workers. This discrepancy led the evaluator to wonder whether the Tr.1 experience in working with alcohol related clients was sufficiently discouraging to produce the lowered attitudes as well as resulted in raising their motivation for alcoholism training in an effort to be more effective. Data regarding these trainees' personal rating of work with alcohol cases and data indicating their level of motivation for training support

our hypotheses that without adequate training in treatment of alcoholism, caseworkers who are most exposed to this work tend to develop a less optimistic view of the disorder and its treatment.

It was interesting to observe that in the individual interviews only 56% of Tr. I indicated that their principal expectation was to get training in alcoholism. The rest of these workers hoped to expand their treatment skills in general by learning new techniques. This might indicate either a defensive attitude, unwillingess to admit the need to feel stronger in treatment of alcoholism, or merely disinterest in alcoholism specifically. However, in view of the data cited above, the former explanation appears to have more grounding.

The training had a clear impact on these trainees. Their average A-O scores increased by 16.3% and their optimism in treating their alcoholic cases successfully increased by 16.2%. At the same time, although the overall caseload of Tr. I decreased, their alcohol related caseload had increased by 4.7% and their view of doing satisfactory work with alcohol related cases they were currently treating improved from 58% to 73%.

Thus, the training had positive effects on Tr. I attitude, practice and view of self as treating agent. The fact that many trainees expected training of a different nature than what

they received did not seem to have a negative effect. On the contrary the individual interviews indicated that the enthusiasm about the training seemed to have been more pervasive after the training than before.

The data at t.3 further indicated that these trainees had not only been affected by the training program, but the effect was maintained more than one year past intervention and, on some important measures, the improvement was still continuing. Again, the data from personal interviews stands in contrast to the data collected by means of other instruments; although there appeared to have been broad gains in attitude and practice with alcoholics, their verbal reports contradicted this. For example, only one trainee on the second round of individual interviews mentioned that the training had any impact on her work with alcohol related clients.

Only during the third round of individual interviews did data accumulate which suggested one possible explanation for this apparent contradiction. One trainee put this most succinctly when she said: "At first I thought it [training] had mostly impact on my work with families... but as time goes on I am realizing I got more in alcoholism than I thought I did." Other trainees implied a similar, slowly growing awareness.

From Tr. I data it appears, therefore, that the training program effected changes in both attitudes and practices of trainees vis-a-vis alcohol related client, but that these effects tended to be outside of the trainees' awareness until they had the opportunity to apply their training for approximately one year.

2. Trainee's II

At the beginning of this project, Tr. II A-O questionnaire scores indicated that these workers had a more positive attitude toward alcohol and alcoholism than either Tr. I or all other caseworkers. They also appeared to have been much more assured of their ability to work with alcoholic clients, as indicated by their estimates of expected success, and with all alcohol related cases, as indicated by their reports of satisfactory progress. Furthermore, not only did Tr. II present themselves as more assured in their work with alcohol problems, they also seemed to view the alcoholic client in the context of prognosis as more like the general client than did either Tr. I or the non-trainees. However, despite this high level of assurance, even at t.1, they were on the average more motivated to participate in the training program than were those workers who were non-trainees.

After the first group of trainees finished their training, the data was examined for indices of a "ripple effect", i.e., the impact of change directly generated by an intervention in one group on other groups which are in close contact. It was especially interesting to look for the effects the first round of training might have had on the workers who, although not yet an identified group, later would become trainees themselves.

Since Tr. I indicated positive changes following training, it was contrary to expectation that Tr. II attitudes and expected rate of success of work with alcoholic cases declined, just as their proportion of alcohol related cases decreased. At the same time, their motivation for the training had increased. The results seemed to indicate that these workers were readying themselves to volunteer for the training. Perhaps they now looked at their alcohol cases more critically and began to re-evaluate their work with the outcomes of treating these cases. It is interesting to look at this possibility in view of the stated expectation for the program which Tr. II shared at the end of their training period. That is, 68% of these trainees focused on their expectation of training in family therapy rather than alcoholism; though it did appear that some of the Tr. II felt that family therapy training would enable them to work better not only with families in general, but also facilitate their work with alcohol related clients.

The effects of training indicated that although Tr. II alcohol related attitudes had become more positive, and there were some gains in practice, the improvement was not as dramatic as it was in the first group of trainees. Their most significant change i.e., the difference in estimates of success in achieving maximum realistic goals with their general clients and alcoholic clients, appears in Tr. II ds scores. The results indicated that not only did they not view their work with alcoholic clients as differently from work with other clients as did Tr. I, but after the training they decreased this score even further. This was consistent with the philosophical stance of the training, i.e., alcohol abuse deviance, just as any other individual deviance, is a symptom of family dysfunction.

Thus, the data collected from Tr. II could be considered as a testimonial, to the greater integration of alcoholism and family therapy training in the second round. The sentiment of one trainee in the first group, i.e., "Trainers viewed alcoholism as no different from any other deviance, whereas lecturers had just the opposite view," was not echoed in the second group. Nevertheless, since some of the leadership at the participating agencies were dubious about the philosophy and technology of the training, this type of result fostered feelings of disappointment in that the training was not more directly focusing on alcoholism and its treatment as a distinctly different deviance.

Further, as noted previously, those trainees who expected to learn more about family therapy were especially pleased with the training immediately after training, whereas trainees who were displeased with the lack of direct attention to and integration of alcohol problems in the training, became more positively disposed to the training experience and its effects over time. The responses on the individual interviews seven months post-training indicated that most of these trainees experienced considerable improvement in their work with alcoholic and other alcohol related clients.

In summary, data from the two major instruments, A-O and CL indicated that the project's intervention had a positive impact on both sets of trainees. It is unclear why Tr. II demonstrated no "ripple effect" post-Tr. I training. However, the lag in trainees awareness of change as demonstrated by data collected from individual interviews, suggests that Tr. I influence on other workers might have become more significant over time. This provides an additional basis for explanation of the data regarding the project's impact on the agencies' policies discussed in the next section.

D. Effect of the Intervention on Agencies' Policies.

A major anticipated and desired result of the intervention strategy employed in this project was the establishment of the participating family agencies as a more effective and available resource in the network of alcoholism services. In part it appeared that the agencies, prior to the intervention, were reluctant to identify themselves as a ready resource for the treatment of alcohol related problems. There was a sense of lack of expertise in dealing with the alcohol problemed client, especially in getting the "drinker" into and keeping her/him in treatment.

The training program did produce a cadre of workers who were more willing to work with the alcoholic person and a number of measures indicated they were more effective in their work with this group of clients. However, the agencies as a group were by the end of the project actively treating smaller proportions of alcohol related cases and problem drinkers than when the project began, perhaps in part due to the increased publicity given to the establishment of detoxification centers during this period.

Though the agencies were, at the end of the project period, more "tooled up" in the treatment of alcoholism and related

problems, this enhanced capability was not communicated to the public via mass media announcements or in the public relations pieces distributed by the agencies. Region West was making a number of reach out efforts to the local alcoholism agencies and there were some beginning indication by the end of the data collection period that these contacts were beginning to produce referrals.

Although the agencies, with the exception of Region West, were not aggressive in reaching out into the community and identifying themselves as resources for alcohol problems, the top level administrators did spend time and effort during the project period in trying to build on the gains made and develop a fundable proposal which would have established the family agencies as central in a comprehensive service network. This effort, however, following completion of a draft proposal became dormant when the funding picture turned bleak.

From the beginning, the agencies' executives as a group expressed ambivalence towards the project. Money difficulties, as well as philosophical/theoretical issues, were involved in generating the ambivalence. As the training program and evaluation component developed, however, there were marked reductions in the negative and critical feelings by the agencies'

leadership. It appears that the amount of support for the project and the amount of overall positive change in the significant measures related to alcoholism in each agency were positively correlated with the proportion of trainees and with the proportion of supervisory level staff participating in the training.

It is not surprising to find that the support of senior staff is critical in effecting change in organizations and especially so with organizational structures similar to large family agencies in which seniority and supervision have powerful influences. Thus, in retrospect, it is believed that the project staff placed insufficient emphasis and/or demand for participation of senior staff in the training program.

Finally, as indicated at the end of the previous section, some indications exist that there is a "lag" in change operating at the agency level. The indications in data collected from trainees correspond to some events reported by the agency executives. For example, months following completion of the training sequence, indications that some of the agencies were developing sanctioned in-house alcoholism consultation capabilities began to emerge. To the best of the project staff's awareness, however, no outside alcoholism consultants were

brought into the agencies during and for a year after the training program. On the other hand, family therapy consultants of the same persuasion as the project trainees were hired, largely at the request of trainees.

In summary, it seems that if the trainees' influence over the rest of the staff and agencies policies is to grow and thus produce a promising atmosphere toward meeting the needs of the person with alcohol problems, additional stimulation and support from outside sources such as alcoholism consultants or close associations with detox centers will be required. The pressure to meet other demands is great and, in relative terms, the alcoholic is still not viewed as a highly desirable client by family agencies.

E. Summary

In the context of this project the training intervention may be considered to have been an experiment with one replication.

At the end of each of the two training periods a similar amount of positive attitude change was generated in each of the training groups. Further, the pattern of change on a number of measures directly related to practice of the two groups of trainees was similar, although the magnitudes differed.

The results also indicate that positive attitude change occurred among staff members who did not participate in the training. However, this change was reflected in their practice measures only in a few instances. This seeming paradox becomes more understandable in the context of the selective assignment of alcohol related cases to the "alcoholism experts", i.e., the trainees.

Individual, group and agency characteristics may be useful in explaining certain differences in direction and magnitude of change, however the major outcome -- an intervention was introduced and that a desired change occurred after this intervention -- continues to stand.

There are indications, also, that overtime the change on some significant variables begins to taper off and the trainees awareness of the gains they made on basis of training increases. It is suggested that additional input is required in order to maintain change and sustain momentum created by the project.

Chapter II

RECOMMENDATIONS

Out of the observations of the project's staff and from the analyses of data collected during this project, the following major recommendations for the use of training as an intervention strategy in agencies were developed.

1. Leadership Involvement

(a) From the earliest stages of proposal development the administrative staffs of each potentially participating agency must be directly and actively involved in the planning and design of a project. Not only are the administrators of agencies the readiest source of information regarding variables within the agency which might influence the course and results of the intervention, but it is likely that their motivation to support a project's goals would be directly proportional to their level of involvement in its planning and design.

(b) An intervention based on training must have broad representation from the agency's senior and supervisory staff as participants in the training. This is especially important when the training program introduces concepts and skills not generally known to or practiced by the predominant majority of the staff. Without adequate representation of senior and supervisory staff in the training, those workers who participate in such training might experience feelings of isolation and/or inadequate agency support for using their newly acquired attitudes and skills. (See Chapter 12 for a more detailed development of this recommendation).

2. A Training Model

The training program must be designed in such a manner that each component has a comprehensible relationship to the other components and that stages of training build on each other, thus reinforcing the material learned and providing a grounding for subsequent material. (See Chapter 12 for a more detailed development of this recommendation).

3. Consultation as a Continuing Intervention

In order to capitalize on the momentum created by a short term training program, continuing support for newly learned attitudes and skills is necessary. This is particularly so when the concepts and techniques introduced by the training differ from those generally practiced at the agency. Initially, this support could be provided in the form of ongoing consultation, external to the agency, which is also designed to foster and build an in-house consultation capacity. (See Chapter 12 for a more detailed development of this recommendation).

4. New Workers

When an agency is actively engaged in an intervention designed to produce change within its own organization, and the intervention involves an impact on the staff directly, then it is imperative that any new staff acquired be actively informed about the intervention and their cooperation enlisted. This procedure is believed to be of value in maximizing the interventions' desired effects.

5. Publicity

In order to deliver an increased quantity of a service for which the agency is not well recognized, a specific effort to "let the world know" must be part of the intervention. Just as the new skills acquired need exercise in order to develop their effectiveness, so actions at the agency level must be taken to reinforce the changes in attitudes and skills of the staff.

Thus, following an intervention which produces a new or enhanced capability, it appears desireable for the agencies to publicly acknowledge this change, e.g., in the media and their own promotional material, in order to continue the momentum established and thus increase the probability of a more lasting change in practice.

6. Relationship Between Training and Evaluation

It is highly desirable to have the evaluation and training staffs as both part of the same organization in order to enhance the interdependence in making both research and program decisions. This approach is particularly important in evaluation studies of an intervention's impact.

Since the ultimate purpose of evaluation is to improve, not to prove, then a responsive communication and feedback system between research and program components is essential for achieving optimum results.

Chapter 12

OUTLINE FOR A MODEL TRAINING PROGRAM

Based on the project staff's observations and on the feedback from trainees and other staff about their experience with the training program, the following design for teaching competencies in working with alcohol problemed people was developed. The design calls for four stages of training, each stage building on the learning that takes place in the preceding stage.

It is believed that if such training was to be introduced into an agency for purposes of improving the skills of on-line workers, the administrative staff of the agency should be requested to participate in at least the first stage of training. Further, it is considered to be of utmost importance for a substantial proportion (at least 50%) of supervisory personnel to participate in all stages of training.

1. Stages of Training

(a) Expand basic knowledge about alcohol and alcoholism.

(b) Change/modify attitude toward alcohol and alcoholism.

(c) Discover/learn new skills in working with alcohol abuser and his/her family

(d) Stimulate interest in and thus facilitate continued learning about alcohol and alcohol abuse.

(a) Expanding Knowledge about Alcohol and Alcoholism.

LECTURE/DISCUSSION SESSIONS are to be supplemented by recommended readings and be designed to impart information or expand knowledge about various aspects of alcohol consumption and alcoholism. Areas to be emphasized include: cultural aspects relevant to viewing alcohol use and alcoholism; behaviors suggestive of alcohol abuse and incipient alcoholism; physiological variables of alcohol and alcoholism (including medical complications); realistic goal setting and reasonable expectations of clients' behavior; community resources available to the alcohol abuser and his/her family; survey of therapy/rehabilitation models successfully used with alcoholics and their families; visits to detoxification centers, half-way houses, AA and Al-Anon meetings.

Each session begins with a 20 minute mini-lecture on one of the topics ennumerated above. Maximum time is then devoted to discussion.

The lecturer/presentor is present during the discussion as the resource person; the discussion, however, is facilitated by a specialist in group process whose skills provide opportunities to generate and capture the energy of the participants/trainees. In this manner it is expected that an informed, lively,

personally engaging discussion would be promoted.

It is assumed that the advantage of devoting a major portion to discussion time facilitated by a specialists in group process would be in the greater assurance that facts/information transmitted to the participants have a quality of personal discovery rather than impersonal indoctrination or memorization. It is also assumed that education in which the learner actively participates, such as occurs in a dialogue encounter, is more meaningful, more easily integrated assimilated and retained.

(b) Change Attitudes Toward Alcohol and Alcoholism.

Some attitude change might be expected to occur on the basis of the lecture/discussion sessions. Additionally, however, it is suggested ROLE PLAYING AND SIMULATION sessions be introduced at this level of training.

These sessions would be designed to familiarize the trainee with feelings frequently aroused in the alcoholic person as he/she faces their family, neighborhood, employment, community and therapy situations By these means it is expected that the trainees will have the opportunity to expand their own experiences, get in touch with feelings not previously identified

or experienced, and thus enhance their capacity to empathize with alcohol abusers. Further, the trainee would have the opportunity to discover what the alcoholic's needs, wants, perceptions are, and on the basis of this get some clues of how communication of these might be blocked, or unblocked and worked through in therapy.

(c) Discovery and Learning New Skills - Working with the Alcohol Abuser and His or Her Family

Both the lecture/discussion and role playing/simulation sessions are designed to expand the therapeutic/intervention skills of the trainees. Additionally, however, it is suggested that DEMONSTRATION SESSIONS be conducted by experienced therapists. Demonstration sessions are to be with "live clients" and followed by extensive discussion.

The selection of "demonstrating therapists" is to be based on the uniqueness of the approach used, e.g., action techniques in family therapy, sensitization and aversive techniques in behavior modification therapy, sense awakening techniques in gestalt therapy, and on the ability of the therapist to articulate the theoretical framework from which he/she operates.

The initial lecture/discussion sessions are to provide a particularly valuable framework for discussion of the theoretical aspects of the demonstration, just as the role playing/simulation sessions have additional use to each trainee in choosing which therapy approach he/she might want to adapt and explore further. Having been exposed to the variety of therapeutic approaches, each trainee has the opportunity to chosse the approach most comfortably adaptable by him/her. Optimally this phase is to be followed by the trainees functioning as co-therapists... as co-therapists and experiencing how each has adopted the new techniques into practice, before working independently with a live client. This activity is again to be followed by extensive processing.

(d) Stimlating Interest in and Thus Facilitating Continued Learning About Alcohol and Alcoholism.

All of the previous steps of this training program are designed to stimulate the trainees' interest in alcohol-related problems and thus, after the termination of the formal training, the trainees are expected to continue their learning in the field of alcoholism. Additionally, in order to assure that the momentum of new learning is utilized we suggest that each trainee

have a continued access to SUPERVISORY AND/OR CONSULTATIVE professional specialists in alcoholism. The supervisors or consultants would be available on the basis of a specific request from one or group of previously trained workers. Additionally, an agreed upon consultant would make regularly scheduled (once or two times/year) consulting visits. At these times all staff of a particular agency or an institution could be invited to participate in the session.

2. Flexibility of Training

The training program design recommended above incorporates three important elements which give it a flexible quality:

(a) The design allows for training in a range of treatment modalities. The design takes into account that the range of apparent causes of alcoholism are broad and varied and so are the range of treatment approaches. Any one technique that is used in the treatment of every alcoholic person is bound to fail in many instances.

(b) The design allows for application to generic agencies other than family agencies and to disciplines

other than social work. Among generic agencies considered appropriate are; settlement houses, multi-service centers, community centers, visiting nurse associations, and churches.

(c) The design has a spiral quality; each stage of the training builds and expands the experiences occurring in the previous stages. Any staff member can participate in the first stage of training, or in the first and second stages of training, or in the first, second and third stages of training without the necessity of continuing with following stage(s) of the training program. This would enable those staff members who are less clinically involved with alcohol related cases to partake of only the amount of training they would deem necessary for their position and then stop, while others enrolled in the program might continue further.

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APPENDICES

APPENDIX A

Instruments

A-1 Executives' Questionnaire

A-2 Attitude-Opinion Questionnaire

A-3 Caseload Questionnaire

A-4 Alcoholism Information Questionnaire, Form H

A-5 Alcoholism Information Questionnaire, Form L

A-6 Alcoholism Information Questionnaire, Form BK

Appendix A.

FAMILY SERVICE AGENCY EXECUTIVES' ALCOHOLISM QUESTIONNAIRE

JCS Alcoholism Project
September, 1972

A. Agency's Staffing Patterns (Casework):

1. Number of senior supervisors at your agency.

Name of Location	Number

2. Number of full time caseworkers at your agency.

Name of Location	Number

3. Number of part-time (at least half-time) caseworkers at your agency.

Name of Location	Number

B. Agency's Policies and Practices:

Definition

For purposes of this questionnaire, "problem drinking" or alcoholism is considered to exist for the individual:

a. when his or her work is materially reduced in efficiency and dependability in large part because of drinking;

b. when drinking is not an isolated experience but is more or less repetitive;

c. when such drinking results in recognizable interference with health and personal relations.

1. Does your agency exclude any category of alcoholic patient?
   Yes No
   If Yes, please describe the basis for exclusion.

2. What do you consider to be the maximum goal(s) that can be realistically accomplished for the alcoholic patient through his treatment?

3. From your experience over the past year what tends to happen to alcoholic patients after they have received treatment in your agency?

4. In your opinion, how will the alcoholics and their families served by your agency benefit as a result of the UCS training program beginning in October?

5. In your opinion, how will your agency benefit from the UCS training program beginning in October?

C. Personal Attitude Inventory:

The following statements are primarily concerned with attitudes and opinions, rather than matters of fact. Therefore, there are no right or wrong answers.

Please answer every question, giving the first answer which comes to mind, rather than stopping to think through any statement; we are interested in your spontaneous feelings rather than in carefully considered judgments.

For each statement, please circle the number placed below the response which most nearly represents your own attitude. Circle one alternative for each statement indicating whether in general you definitely agree, tend to agree, tend to disagree or definitely disagree.

	Def. Agree	Tend to Agree	Tend to Disagree	Def. Disagree
1. The sanctioning of heavy drinking in a social or cultural group is a factor in causing alcoholism.	1	2	3	4
2. Individuals who voluntarily abstain from drinking are better off than those who take any alcohol.	1	2	3	4
3. People who become alcoholics are usually lacking in will power.	1	2	3	4
4. The immediacy of an alcoholic's demands makes it very difficult to maintain a professional relationship with him.	1	2	3	4
5. It is hard to be truly accepting of alcoholics, when one considers how seriously they damage their children.	1	2	3	4
6. Treatment of alcoholics is beyond the skill of many social workers.	1	2	3	4
7. Alcoholism is primarily the result of physiological predisposition.	1	2	3	4
8. Very little can be done to help an alcoholic solve his other problems until he first stops drinking.	1	2	3	4
9. Alcoholism undermines the ethical standards of the alcoholic.	1	2	3	4
10. Wives of alcoholics have an emotional need for their husbands to continue drinking.	1	2	3	4
11. If an alcoholic fails to stay in treatment the responsibility for breaking off contact usually lies with him.	1	2	3	4
12. Alcoholism is primarily the result of underlying emotional problems.	1	2	3	4
13. Casework with the alcoholic's wife can often result in motivating the alcoholic to seek help.	1	2	3	4
14. An alcoholic is harder to relate to than an individual whose illness is not self-inflicted.	1	2	3	4

		Def. Agree	Tend to Agree	Tend to Disagree	Def. Disagree
15.	Life-long abstinence is a necessary goal, although not the only goal, of treatment.	1	2	3	4
16.	Motivation of the alcoholic for treatment is often effective when brought about under external duress.	1	2	3	4
17.	Symptomatic treatment which succeeds in stopping the drinking is frequently enough help to enable an alcoholic to mobilize his resources and develop a satisfying life.	1	2	3	4
18.	Wives of alcoholics often prematurely break off treatment because these women do not really want help.	1	2	3	4
19.	Alcoholism is a disease.	1	2	3	4
20.	The majority of alcoholics can recover with treatment.	1	2	3	4
21.	If an alcoholic fails to stay in treatment, the responsibility usually lies with the professional.	1	2	3	4
22.	Before an alcoholic is able to stop drinking, he needs to gain some insight into the reasons for his drinking.	1	2	3	4
23.	It is discouraging to work with wives of alcoholics, because so few of these women show any improvement.	1	2	3	4
24.	The alcoholic is hard to work with because social workers believe he is hard to work with.	1	2	3	4
25.	If an alcoholic can be helped to gain some insight into the reasons for his drinking, the amount he drinks will decrease.	1	2	3	4
26.	Using moderate amount of alcohol to relax from tension is beneficial for the individual.	1	2	3	4

NCS ALCOHOLISM PROJECT
QUESTIONNAIRE

Personal Information and Experience.

NAME CODE:_____

Employed at the Agency:

Full time_____ Part time_____

How many years?_____

SECTION I.

1. Are you currently participating in any in-service training programs?

Yes_____
(please specify)

No_____

2. Do you have any previous experiences with group approaches?

Yes_____ No____

If yes, was it:

Therapy group _____
Training group_____
Encounter group_____
Other _____
(Please specify)

3. Do you have specialized training in family therapy?

Yes_____ No_____

If yes:

Where_____

When _____

How long _____

4. Do you have any specialized training in working with an alcoholic client and/or his family?

Yes_____ No_____

If yes:

Where_____

When _____

How long_____

5. Indicate % of alcoholic clients in your current caseload with whom you expect to realize maximum realistic goals.

10%	60%	
20%	70%	
30%	80%	
40%	90%	(Please circle)
50%	100%	

6. Indicate % of clients in your current caseload, exclusive of alcoholics, with whom you expect to realize maximum realistic goals.

10%	60%	
20%	70%	
30%	80%	(Please circle)
40%	90%	
50%	100%	

7. Indicate your motivation for participating in the UCS training program.

Very low _____
Low _____
Neutral _____
High _____
Very High _____

SECTION II.

Alcoholism Questionnaire.

The following statements are primarily concerned with attitudes, opinions, and reflections thereof, rather than matters of fact. Therefore, there are no right or wrong answers.

Please answer every question, giving the first answer which comes to mind, rather than stopping to think through any statement; we are interested in your spontaneous feelings rather than in carefully considered judgements.

For each statement, please circle the number placed above the response which most nearly represents your own attitude or opinion. Circle only one alternative for each statement indicating whether in general you definitely agree, tend to agree, tend to disagree, or definitely disagree.

		Def. Agree	Tend to Agree	Tend to Disagree	Def. Disagree
1.	I drink only at very special occasions.	1	2	3	4
2.	Alcoholism is best described as a habit.	1	2	3	4
3.	Young people should be taught how to use alcoholic beverages by their parents.	1	2	3	4
4.	Individuals who voluntarily abstain from drinking are no better off than those who take any alcohol.	1	2	3	4
5.	People who become alcoholics are usually lacking in will-power.	1	2	3	4
6.	The immediacy of an alcoholics's demands makes it very difficult to maintain a professional relationship with him.	1	2	3	4
7.	Most therapists' initial reaction to an alcoholic client is that of aversion.	1	2	3	4
8.	Alcoholism is a general term covering a variety of conditions.	1	2	3	4

	Def. Agree	Tend to Agree	Tend to Disagree	Def. Disagree
9. It may be wrong of me, but in all honesty I am more likely to feel annoyed by an alcoholic than be sympathetic to him.	1	2	3	4
10. Very few alcoholics come from families in which both parents are abstainers.	1	2	3	4
11. It is hard to be truly accepting of alcoholics when one considers how seriously they damage their children.	1	2	3	4
12. Lifelong abstinence is a necessary goal, although not the only goal in treating alcoholism.	1	2	3	4
13. Treatment of the alcoholic is beyond the skill of social workers.	1	2	3	4
14. Very little can be done to help an alcoholic solve his other problems until he stops drinking.	1	2	3	4
15. Moderate use of alcoholic beverage is socially valuable.	1	2	3	4
16. The benefits of alcoholic beverage far outweigh its alleged harm.	1	2	3	4
17. Wives of alcoholics have an emotional need for their husbands to continue drinking.	1	2	3	4
18. Alcoholics, on the average, have poorer education than other people.	1	2	3	4
19. If an alcoholic fails to stay in treatment, the responsibility for breaking off contact usually lies with him.	1	2	3	4
20. Most alcoholics have no desire to stop drinking.	1	2	3	4
21. Casework with the alcoholic's wife can often result in motivating the alcoholic to seek help.	1	2	3	4

		Def. Agree	Tend to Agree	Tend to Disagree	Def. Disagree.
22.	Alcoholism is primarily the result of underlying emotional problems.	1	2	3	4
23.	Most therapists' initial reaction to an alcoholic client is a feeling of helplessness.	1	2	3	4
24.	An alcoholic is harder to relate to than an individual whose illness is not self-inflicted.	1	2	3	4
25.	The beverage use of alcohol should generally be discouraged.	1	2	3	4
26.	The motivation of the alcoholic for treatment is not effected by external duress.	1	2	3	4
27.	Alcoholism is a disease.	1	2	3	4
28.	Wives of alcoholics often prematurely break off treatment because these women do not really want help.	1	2	3	4
29.	I dislike working with alcoholics.	1	2	3	4
30.	The proportion of effective treatment in alcoholism can be equal to effective treatments of any other category of clients.	1	2	3	4
31.	Using a moderate amount of alcohol to relax from tension is beneficial for the individual.	1	2	3	4
32.	If an alcoholic fails to stay in treatment, the responsibility usually lies with the professional.	1	2	3	4
33.	It is discouraging to work with wives of alcoholics, because so few of these women show any improvement.	1	2	3	4
34.	The alcoholic is hard to work with because social workers believe he is hard to work with.	1	2	3	4
35.	An occasional social drink does nobody any harm.	1	2	3	4

		Def. Agree	Tend to Agree	Tend to Disagree	Def. Disagree
36.	The majority of alcoholics can recover with treatment.	1	2	3	4
37.	When I suspect that excessive drinking may be an important factor in a client's problem, I am reluctant to deal with that aspect of the problem.	1	2	3	4
38.	Most alcoholics are either drunk or drinking every day.	1	2	3	4
39.	The best thing that can happen to an alcoholic is to have the members of Alcoholics Anonymous take over the responsibility for helping him.	1	2	3	4
40.	The alcoholic is usually a weak person.	1	2	3	4
41.	If an alcoholic succeeds in achieving lasting sobriety, his wife will become more distrubed.	1	2	3	4
42.	Most alcoholics are completely unconcerned about their drinking problem.	1	2	3	4
43.	Alcoholism has so many special features that its professional treatment should be referred to clinics, hospitals, and physicians that specialize in alcoholism.	1	2	3	4
44.	An alcoholic usually has something in his past which is driving him to drink.	1	2	3	4
45.	Most alcoholics have no desire to stop drinking.	1	2	3	4
46.	The alcoholic is seldom helped by any sort of medical or psychological treatment.	1	2	3	4
47.	Wives of alcoholics often do not want their husband to stop drinking because these wives are afraid that his abstinence will interfere with social activities.	1	2	3	4

		Def. Agree	Tend to Agree	Tend to Disagree	Def. Disagree
48.	The alcoholic drinks excessively mainly because he enjoys drinking.	1	2	3	4
49.	Forcing an alcoholic to face and suffer the consequences of his behavior often increases his motivation for treatment.	1	2	3	4
50.	Most alcoholics could not be rehabilitated even if more help were available for them.	1	2	3	4
51.	Anyone who has ever had experience with an alcoholic knows that they tend to be weak willed.	1	2	3	4
52.	A married alcoholic is more likely to experience successful treatment if both spouses are seen in therapy.	1	2	3	4

Appendix A

UCS ALCOHOLISM PROJECT

RELEASE FORM

(Required by U.S. Department of Health, Education and Welfare)

It is my understanding that the information contained in the enclosed questionnaire will be held in the strictest confidence and be available only to members of the research staff. Any published reporting of data will be grouped and my responses will in no way be identified.

NAME: _____
(Signature)

AGENCY: _____

BRANCH OFFICE: _____

DATE: _____

NAME CODE: _____

Appendix A

Worker name code: _____

UCS ALCOHOLISM PROJECT

Caseload Questionnaire

1. How long have you been handling this case?

   - ☐ less than one month
   - ☐ 1 to 6 months
   - ☐ 6 months to 1 year
   - ☐ 1 to 2 years
   - ☐ over 2 years

2. How frequently have you had contact with the primary client during this time?

   - ☐ once a week or more frequently
   - ☐ every other week
   - ☐ once a month
   - ☐ less than once a month
   - ☐ irregular contacts
   - ☐ other (specify) _____

3. What was the presenting problem? (describe briefly) _____

4. Was the drinking problem mentioned at intake?

   - ☐ Yes
   - ☐ No

5. Who is the primary client?

   - ☐ the drinker
   - ☐ spouse of drinker
   - ☐ parent of drinker
   - ☐ other (specify) _____

6. Sex of the primary client:

   - ☐ Male
   - ☐ Female

7. Marital status of the primary client:

   - ☐ single
   - ☐ married
   - ☐ separated
   - ☐ divorced
   - ☐ widowed

8. What is the extent of the drinking problem?

   - ☐ steady, constant drinking
   - ☐ regular "binges" (eg. weekends)
   - ☐ infrequent drinking bouts
   - ☐ other (specify) _____

9. Does the primary client have a history of treatment related to the problem of alcohol.

   - ☐ family agency
   - ☐ mental health facility
   - ☐ alcoholics anonomous
   - ☐ other (specify)
   - ☐ length of time in treatment _____
   - ☐ length of time in treatment _____
   - ☐ length of time in treatment _____
   - ☐ length of time in treatment _____

Questions 10-19 refer to the problem drinker:

10. Birthplace:

- ☐ U.S., Mexico or Canada
- ☐ Eastern Europe
- ☐ Western Europe
- ☐ other (specify)_____

11. Age:

- ☐ under 15 years
- ☐ 15 to 24 years
- ☐ 25 to 34 years
- ☐ 35 to 44 years
- ☐ 45 to 54 years
- ☐ 55 to 64 years
- ☐ 65 years and over

12. Sex:

- ☐ Male
- ☐ Female

13. Marital Status:

- ☐ single
- ☐ married
- ☐ separated
- ☐ divorced
- ☐ widowed

14. Religion:

- ☐ Catholic
- ☐ Protestant
- ☐ Jewish
- ☐ Other

15. Educational Level (years of school completed):

- ☐ 8th grade or less
- ☐ 9th through 11 year
- ☐ high school graduate
- ☐ technical training beyond HS.
- ☐ some college
- ☐ undergraduate degree
- ☐ graduate degree
- ☐ Other (specify)_____

16. Income Level:

- ☐ none to $4,000
- ☐ $4,000 - $7,999
- ☐ $8,000 - $11,999
- ☐ $12,000 - $15,999
- ☐ $16,000 - $19,999
- ☐ $20,000 - over

17. Present occupation with brief description of duties (give previous occupation if currently unemployed or retired):

18. Indication of physical deterioration during past year:

- ☐ Yes
- ☐ No

19. History of experience in treatment of alcoholism:

- ☐ Family Agency ☐ length of time in treatment_____
- ☐ Mental Health facility ☐ length of time in treatment_____
- ☐ Alcoholics Anonomous ☐ length of time in treatment_____
- ☐ Other (specify) ☐ length of time in treatment_____

20. How do you rate your present work with the primary client?

Very satisfactory — satisfactory — unsatisfactory — Very unsatisfac.

21.

22.

Name Code_____

UCS ALCOHOLISM PROJECT

Alcoholism Information Questionnaire
Form H

On the following questions, indicate the correct answer by circling either T (true) or F (false).

T F 1. Historically, the distribution of alcoholic beverages occured prior to the brewing of beer.

T F 2. Moderate drinking, as we understand it, was rare among pre-literate groups.

T F 3. The first personal use of alcohol is typically reported to have been with a friend or group outside of the home.

T F 4. The prevalence of drinking among adolescents in the community is dependent on legal restraints specifically designed to prevent or discourage drinking among minors.

T F 5. What the adolescent learns about drinking from the mass media, the church and the school is, if there is conflict, typically subordinate to what he learns from his parents and peers.

T F 6. Alcoholism in the United States is not significantly related to ethnic origins.

T F 7. A large proportion of the alcoholics in America today are less than 20 years of age.

T F 8. Most alcoholics are on skid row.

T F 9. The majority of men and women suffering from alcoholism in the United States are married.

T F 10. The probability is high that every adolescent in our society will have used an alcoholic beverage at least once before being graduated from high school.

T F 11. Alcohol is described medically as a depressant.

T F 12. Alcohol affects physical skills before it affects mental abilities of the drinker.

T F 13. The rate at which the level of alcohol in the blood falls is changed by exercise, exposure to cold, or various types of shock.

T F 14. An individual who had been taking the drug Antabuse is able to drink only moderately.

T F 15. Absenteeism in industry is a clue to alcoholism of the employee.

T F 16. In order to become a member of AA one must believe in some religious creed.

T F 17. In an alcoholic's family the non-alcoholic mother frequently denies that the children know of the alcoholism problem in their family.

T F 18. Expression of feelings in the alcoholic's family is usually overt.

T F 19. The frantic and demanding behavior of an alcoholic's wife, when she applies for help often reflects her feeling that such behavior is the only thing that gets any results.

T F 20. The alcoholic husband's anti-social behavior causing conflict with the law is a minor factor in threatening his family's security.

T F 21. The success rate for alcoholics in alcoholism clinics appears to be comparable to that of general phsychiatric cases in mental health clini

T F 22. Most half-way houses will accept only clients who are sober at the time of application.

T F 23. The most serious shortcoming of alcoholism programs is the almost total absence of after-care and follow up programs and activities.

T F 24. Skid row men are never employed.

T F 25. The skid row areas are declining.

T F 26. Since the 1960's the trend has been for industrial and business companies to include the treatment of alcoholism as part of the companies general employee health policy.

T F 27. The average experiences of companies with effective programs shows that the proportion of long-term recovery for alcoholic employees after initial rehabilitation is over 50% of those accepting treatment.

T F 28. Seeing alcoholism in a medical-health context has had no effect on substitution of helping or healing approaches in place of punitive and judgmental approaches.

T F 29. One of the procedures provided by the State Department of Mental Health in Mass. is a "Voluntary Application" which authorizes the hospital administration to extend the patient's hospitalization indefinitely.

T F 30. The Mass. General Hospital Alcoholism clinic limits their admissions to persons of 16 years of age or older.

ON THE FOLLOWING QUESTIONS CIRCLE EACH LETTER WHICH CORRESPONDS TO THE CORRECT ANSWER. MORE THAN ONE ANSWER PER QUESTION MAY BE CORRECT.

31. Choose the true statement:

(a) Beer drinking alone is not associated with alcoholism.
(b) Alcoholism is a biologically or biochemically caused illness.
(c) Relapses in the course of alcoholism need not be evidences of therapeutic failure.
(d) Antabuse (disulfriam) is a dangerous drug whose use should be avoided.

32. Which one of the following treatments for chronic alcoholism is most widely accepted?

(a) Freudian individual psychotherapy
(b) Group therapy
(c) LSD and hypnosis
(d) LSD alone

33. The aims of treatment of alcoholism include

(a) achieving abstinence
(b) learning to drink socially again
(c) rehabilitation and return to jobs and family
(d) changing to another drug such as barbiturates or heroin

34. The amount of alcohol in the blood of the average size adult at one given time needed to cause death is

(a) 18 beers
(b) a quart of hard liquor
(c) a fifth of hard liquor
(d) 6 martinis

35. Chronic excessive drinking has effects on

(a) the brain and nervous system
(b) the liver
(c) the individual's family
(d) the individual's job

36. Following a heavy bender, the alcoholic patient

(a) may have withdrawal symptoms
(b) very rapidly feel much better
(c) may develop delirium tremens
(d) may soon begin social drinking again

37. Withdrawal from heavy use of alcohol can produce:

(a) Hallucinations
(b) Convulsions
(c) Death

38. Dependence on alcohol may include:
(a) psychological dependence
(b) physical dependence
(c) tolerance

39. Alcoholics are

(a) seldom seen in hospitals
(b) commonly seen in general and psychiatric hospitals
(c) only seen in psychiatric hospitals
(d) only seen in general hospitals

40. Female alcoholics appear to be:

(a) more psychopathological than male alcoholics
(b) less psychopathological than male alcoholics
(c) the same, psychopathologically, as male alcoholics
(d) not emotionally disturbed

41. In the United States alcoholism is

(a) more common among women than men
(b) more common among men than women
(c) as common among women as among men

42. Most people who become alcoholics

(a) have a personality disorder
(b) have alcoholic parents
(c) use alcohol as a escape

43. In industry, alcohol-related problems

(a) are rare
(b) are a common cause for absenteeism
(c) are a common cause for loss of job
(d) are a common cause for job promotion

44. Compared with the general population, alcoholics

(a) have a longer life span
(b) have a shorter life span
(c) live as long as others

45. Which percentage of alcoholics are skid row?

(a) less than 10 per cent
(b) about 50 per cent
(c) over 50 per cent

46. List the possible medical complications of alcoholism treatment.

Name Code_____

UCS ALCOHOLISM PROJECT

Alcoholism Information Questionnaire
Form L

T F 1. Alcoholism was rare among pre-literate groups.

T F 2. The prevalence of drinking among adolescants in the community is not dependent on legal restraints specifically designed to prevent or discourage drinking among minors.

T F 3. The first personal use of alcohol is typically reported to have been in the home with a family member or friend.

T F 4. Today about 75% of the states in the U.S. require that some education about alcohol and its usage be given in the public High Schools.

T F 5. Among Americans, alcoholism is related to early drinking.

T F 6. Most drinking among high school students is of beer and wine.

T F 7. A person has to consume alcoholic beverages daily to be classified as an alcoholic.

T F 8. The minority of men and women suffering from alcoholism in the United States are married.

T F 9. The probability is low that every adolescent in our society will have used an alcoholic beverage at least once before being graduated from high school.

T F 10. The suicidal rate among alcoholics is very low.

T F 11. Alcohol is described medically as a stimulant.

T F 12. Once alcohol is in the blood it is distributed throughout the body, but the area most sensitive to its action and effect is the liver.

T F 13. Alcohol is a member of the anesthetic series of drugs.

T F 14. Like water and unlike other foodstuffs, alcohol does not require digestion.

T F 15. The individual who is of a suspicious nature becomes more suspicious as he drinks alcoholic beverages.

T F 16. In the early stages of alcoholism the individual can control the amount he drinks on any occasion.

T F 17. As an alcoholic's family repeatedly fails in its efforts to cope with the problem of alcoholism it tends to become less vulnerable to other crises.

T F 18. In an alcoholic's family the non-alcoholic mother frequently lacks the awareness that the children are affected by the father's drinking.

T F 19. Although Al-Anon is composed primarily of the spouses of alcoholics, parents, relatives, children over 21 and interested friends at times have also become members.

T F 20. The alcoholic husband's anti-social behavior causing conflict with the law is a major factor in threatening his family's security.

T F 21. The alcoholic wife's frantic and demanding behavior when she applies for help often reflects her feeling of helplessness.

T F 22. The "success" rate for alcoholics in alcoholism clinics appears to be considerably lower than that of general psychiatric cases in mental health clinics.

T F 23. Half-way houses for alcoholism are established primarily for the homeless alcoholics who do not require complete custodial care, but rather long term protective support.

T F 24. Alcohol is central to the way skid row institutions operate.

T F 25. All of the skid row area residents do belong to the skid row community.

T F 26. Probably close to 50% of all problem drinkers in America are currently employed and, consequently, industry is an unequalled setting for early case finding.

T F 27. So far very few major life insurance companies have alcoholism programs for their employees.

T F 28. Seeing alcoholism in a medical-health context has had an effect on substitution of helping and healing approaches in place of punitive and judgmental approaches.

T F 29. One of the commitment procedures provided by the State Department of Mental Health in Massachusetts is a Temporary Care Paper and court action is necessary to make the commitment paper valid.

T F 30. In Massachusetts one of the more comprehensive programs designed for the treatment of alcoholism is at the Lemuel Shattuck Hospital.

ON THE FOLLOWING QUESTIONS CIRCLE EACH LETTER WHICH CORRESPONDS TO THE CORRECT ANSWER. MORE THAN ONE ANSWER PER QUESTION MAY BE CORRECT.

31. Once people develop alcoholism:

(a) they can never drink socially again
(b) they very often become social drinkers again
(c) in rare cases they become social drinkers again

32. The best predictors of success in alcoholism treatment are:

(a) psychological tests
(b) psychiatric diagnosis
(c) past social and economic behavior
(d) presence of delirium tremens

33. Excessive amounts of the following substances can lead to alcohol addiction:

(a) beer
(b) spirits
(c) wine
(d) amphetamines

34. A predisposition to alcoholism appears to be:

(a) genetic
(b) nutritional
(c) psychological
(d) unknown

35. Alcholics often feel:

(a) proud of their alcoholism
(b) ashamed of their alcoholism
(c) nothing about their alcoholism.

36. Which of the following conditions occur very commonly among alcoholics?

(a) delirium tremens
(b) liver disease
(c) kidney disease
(d) loss of hair

37. Which of the following conditions is/are uncommon among alcoholics?

(a) suicide
(b) divorce
(c) controlled beer drinking
(d) frequent job promotions

38. Chronic alcoholism resembles most closely:

(a) schizophrenic psychosis
(b) heroin dependence
(c) anxiety neurosis
(d) manic-depressive illness

39. The alcoholic's family usually is:

(a) unhappy
(b) happy
(c) no different from the rest of the population

40. The best single bit of advice for most wives of alcoholic men is:

(a) Alcoholism is incurable; divorce or permanent separation is the answer
(b) Join Al-Anon for better understanding
(c) drink along with your husband as he needs you
(d) try to cure him by pointing out how he's harmed you and the children

41. The ratio of female to male alcoholics in the United States is:

(a) 1 to 1
(b) 1 to 3
(c) 1 to 5
(d) 1 to 20

42. In the United States the cost of alcoholism to the employers in business and industry has been approximated to be:

(a) $25,000/year
(b) $50,000/year
(c) $100,000/year
(d) $1,000,000/year

43. The most common age group for alcoholism is:

(a) 0 - 25 years
(b) 26 - 50 years
(c) 51 + years

44. In the United States there are

(a) more drug addicts than alcoholics
(b) more alcoholics than drug addicts
(c) about as many alcoholics as drug addicts

45. Compared with the general population, drunken drivers cause:

(a) relatively fewer accidents
(b) relatively more accidents
(c) the same proportion of accidents

46. List the possible medical complications of alcoholism treatment.

Name Code_____

Appendix A

UCS ALCOHOLISM PROJECT

Alcoholism Information Questionnaire

Form BK

T F 1. Alcoholism was rare among pre-literate groups.

T F 2. Historically, the distribution of alcoholic beverages occured prior to the brewing of beer.

T F 3. In Michigan following the lowering of the legal drinking age to 18, the number of auto accidents in the 18-21 age group has increased substantially.

T F 4. The first personal use of alcohol is typically reported to have been with a friend or group outside of the home.

T F 5. Today about 75% of the states in the U.S. require that some education about alcohol and its usage be given in the public high schools.

T F 6. The prevalence of drinking among adolescents in the community is dependent on legal restraints specifically designed to prevent or discourage drinking among minors.

T F 7. Among Americans, alcoholism is related to early drinking.

T F 8. What the adolescent learns about drinking from the mass media, the church and the school is, if there is conflict, typically subordinate to what he learns from his parents and peers.

T F 9. Most drinking among high school students is of beer and wine.

T F 10. Alcoholism in the United States is not significantly related to ethnic origins.

T F 11. A person has to consume alcoholic beverages daily to be classified as an alcoholic.

T F 12. A large proportion of the alcoholics in America today are less than 20 years of age.

T F 13. Moderate drinking,as we understand it, was rare among pre-literate groups.

T F 14. Most alcoholics are on skid row.

T F 15. The probability is low that every adolescent in our society will have used an alcoholic beverage at least once before being graduated from high school.

T F 16. The majority of men and women suffering from alcoholism in the United States are married.

T F 17. The suicide rate among alcoholics is very low.

T F 18. Alcohol is described medically as a stimulant.

T F 19. Once alcohol is in the blood it is distributed throughout the body, but the area most sensitive to its action and effect is the liver.

T F 20. Alcohol affects physical skills before it affects mental abilities of the drinker.

T F 21. Alcohol is a member of the anaesthetic series of drugs.

T F 22. The rate at which the level of alcohol in the blood falls is changed by exercise, exposure to cold, or various types of shock.

T F 23. Like water and unlike other foodstuffs, alcohol does not require digestion.

T F 24. An individual who had been taking the drug Antabuse is able to drink only moderately.

T F 25. The individual who is of a suspicious nature becomes more suspicious as he drinks alcoholic beverages.

T F 26. Absenteeism in industry is a clue to alcoholism of the employee.

T F 27. In the early stages of alcoholism the individual can control the amount he drinks on any occassion.

T F 28. In order to become a member of AA one must believe in some religious creed.

T F 29. As an alcoholic's family repeatedly fails in its efforts to cope with the problem of alcoholism it tends to become less vulnerable to other crises.

T F 30. In an alcoholic's family the non-alcoholic mother frequently lacks the awareness that the children are affected by the father's drinking.

T F 31. Expression of feelings in the alcoholic's family is usually overt.

T F 32. Although Al-Anon is composed primarily of the spouses of alcoholics, parents, relatives, children over 21 and interested friends at times have also become members.

T F 33. The frantic and demanding behavior of an alcoholic's wife when she applies for help often reflects her feeling that such behavior is the only thing that gets any results.

T F 34. The alcoholic husband's anti-social behavior causing conflict with the law is a major factor in threatening his family's security.

T F 35. The "success" rate for alcoholics in alcoholism clinics appears to be considerably lower than that of general psychiatric cases in mental health clinics.

T F 36. Skid row men are never employed.

T F 37. Most half-way houses will accept only clients who are sober at the time of application.

T F 38. Half-way houses for alcoholism are established primarily for the homeless alcoholics who do not require complete custodial care, but rather long term protective support.

T F 39. The most serious shortcoming of alcoholism programs is the almost total absence of after-care and follow-up programs and activities.

T F 40. All of the skid row area residents do belong to the skid row community.

T F 41. The skid row areas are declining.

T F 42. Probably close to 50% of all problem drinkers in America are currently employed and, consequently, industry is an unequalled setting for early case finding.

T F 43. Since the 1960's the trend has been for industrial and business companies to include the treatment of alcoholism as part of the companies general employee health policy.

T F 44. Alcohol is described medically as a depressant.

T F 45. The alcoholic's wife's frantic and demanding behavior when she applies for help often reflects her feeling of helplessness.

T F 46. So far very few major life insurance companies have alcoholism programs for their employees.

T F 47. The average experiences of companies with effective programs shows that the proportion of long-term recovery for alcoholic employees after initial rehabilitation is over 50% of those accepting treatment.

T F 48. Seeing alcoholism in a medical - health context has had an effect on substitution of helping and healing approaches in place of punitive and judgemental approaches.

T F 49. One of the procedures provided by the State Department of Mental Health in Massachusetts is a "Voluntary Application" which authorizes the hospital administration to extend the patient's hospitalization indefinitely.

T F 50. One of the commitment procedures provided by the State Department of Mental Health in Massachusetts is a Temporary Care Paper and court action is necessary to make the commitment paper valid.

T F 51. The Massachusetts General Hospital Alcoholism Clinic limits their adminissions to persons of 16 years of age or older.

T F 52. In Massachusetts one of the more comprehensive programs designed for the treatment of alcoholism is at the Lemuel Shattuck Hospital.

ON THE FOLLOWING QUESTIONS CIRCLE EACH LETTER WHICH CORRESPONDS TO THE CORRECT ANSWER. MORE THAN ONE ANSWER PER QUESTION MAY BE CORRECT.

53. Once people develop alcoholism:

(a) they can never drink socially again
(b) they very often become social drinkers again
(c) in rare cases they become social drinkers again

54. Choose the true statement:

(a) Beer drinking alone is not associated with alcoholism.
(b) Alcoholism is a biologically or biochemically caused illness.
(c) Relapses in the course of alcoholism need not be evidences of therapeutic failure.
(d) Antabuse (disulfiriam) is a dangerous drug whose use should be avoided.

55. The best predictors of success in alcoholism treatment are:

(a) psychological tests
(b) psychiatric diagnosis
(c) past social and economic behavior
(d) presence of delirium tremens

56. Which of the following treatments for chronic alcoholism is most widely accepted?

(a) Freudian individual psychotherapy
(b) Group therapy
(c) LSD and hypnosis
(d) LSD alone

57. Excessive amounts of the following substances can lead to alcohol addiction:

(a) beer
(b) spirits
(c) wine
(d) amphetamines

58. The aims of treatment of alcoholism include

(a) achieving abstinence
(b) learning to drink socially again
(c) rehabilitation and return to jobs and family
(d) changing to another drug such as barbiturates or heroin

59. A predisposition to alcoholism appears to be:

(a) genetic
(b) nutritional
(c) psychological
(d) unknown

60. The amount of alcohol in the blood of the average size adult at one given time needed to cause death is:

(a) 18 beers
(b) a quart of hard liquor
(c) a fifth of hard liquor
(d) 6 martinis

61. Alcoholics often feel:

(a) proud of their alcoholism
(b) ashamed of their alcoholism
(c) nothing about their alcoholism

62. Chronic excessive drinking has effects on

(a) the brain and nervous system
(b) the liver
(c) the individual's family
(d) the individual's job

63. Which of the following conditions occur very commonly among alcoholics?

(a) delirium tremens
(b) liver disease
(c) kidney disease
(d) loss of hair

64. Following a heavy bender, the alcoholic patient

(a) may have withdrawal symptoms
(b) very rapidly feel much better
(c) may develop delirium tremens
(d) may soon begin social drinking again

65. Which of the following conditions is/are uncommon among alcoholics?

(a) suicide
(b) divorce
(c) controlled beer drinking
(d) frequent job promotions

66. Withdrawal from heavy use of alcohol can produce:

(a) hallucinations
(b) convulsions
(c) death

67. Chronic alcoholism resembles most closely:

(a) schizophrenic psychosis
(b) heroin dependence
(c) anxiety neurosis
(d) manic-depressive illness

68. Dependence on alcohol may include:

(a) psychological dependence
(b) physical dependence
(c) tolerance

69. Alcoholics are:

(a) seldom seen in hospitals
(b) commonly seen in general and psychiatric hospitals
(c) only seen in psychiatric hospitals
(d) only seen in general hospitals

70. The best single bit of advice for most wives of alcoholic men is:

(a) Alcoholism is incurable; divorce or permenent separation is the answer
(b) Join Al-Anon for better understanding
(c) Drink along with your husband as he needs you
(d) Try to cure him by pointing out how he's harmed you and the children

71. Female alcoholics appear to be:

(a) more psychopathological than male alcoholics
(b) less psychopathological than male alcoholics
(c) the same, psychopathologically, as male alcoholics
(d) not emotionally disturbed

72. The ratio of female to male alcoholics in the United States is:

(a) 1 to 1
(b) 1 to 3
(c) 1 to 5
(d) 1 to 20

73. In the United States the cost of alcoholism to the employers in business and industry has been approximated to be:

(a) $25,000,000/year
(b) $50,000,000/year
(c) $100,000,000/year
(d) $1,000,000,000/year

74. Most people who become alcoholics

(a) have a personality disorder
(b) have alcoholic parents
(c) use alcohol as an escape

75. The most common age group for alcoholism is:

(a) 0 - 25 years
(b) 26 - 50 years
(c) 51 + years

76. In industry, alcohol-related problems

(a) are rare
(b) are a common cause for absenteeism
(c) are a common cause for loss of job
(d) are a common cause for job promotion

77. In the United States there are:

(a) more drug addicts than alcoholics
(b) more alcoholics than drug addicts
(c) about as many alcoholics as drug addicts

78. Compared with the general population, alcoholics

(a) have a longer life span
(b) have a shorter life span
(c) Live as long as others

79. Compared with the general population, drunken drivers cause:

(a) relatively fewer accidents
(b) relatively more accidents
(c) the same proportion of accidents

80. Which percentage of alcoholics are skid row?

(a) less than 10 percent
(b) about 50 percent
(c) over 50 percent

81. List the possible medical complications of alcoholism treatment.

Appendix B

THE BOSTON FAMILY INSTITUTE

May 1972

UCS ALCOHOL TRAINING PROJECT

Session 1

Theme: Communication, Systems and Deviancy

Goals: Acquaintence, Group Building, Systems concepts, deviancy

Group Issues: Non-verbal messages, membership

Family Issues: Steps of family formation, system inter-dependencies, degrees of deviancy and system coping processes

Session 2

Theme: Family Processes and alcohol

Goals: Group Building Family Formation insights about alcoholism as a family system phenomenon

Group Issues: Membership, (in-out), roles

Family Issues: Roles, decision making, choices, role playing systems issues, patterns, leadership alcohol as family issue

Session 3

Theme: Personal Family Issues and Alcohol

Goals: Trainees Attitudes and experiences with alcohol and alcoholics and addictions

Group Issues: Sharing, Public and private issues

Family Issues: Tolerance for any deviancy, early learning and early attitudes and feelings. Personal meanings

of different addictions to trainees.

Session 4

Theme: Fighting, Intimacy, Alcoholism and Intervention

Goals: Exploration of Fighting Styles, - "making-up" processes, Therapy of Family with Alcoholic

Group Issues: Flexibility, roleplaying, control

Family Issues: Blame, control, and rule of alcohol, alliances, intimacy

Therapy Issues: Observer roles assigned, cotherapy, boundaries - in and out

Session 5

David Kantor Presentation of Research in Families and Theory of Families

Development of conceptual model and space, boundaries, time affect, meaning.

Session 6

David Kantor - Entry and System Diagnosis - New Ways of Looking at and Dealing with Families Systems with Alcoholics

Session 7, 8, 9

Full Day Workshop - Both Groups

Theme: The Therapist in the self - Person, and Therapist, and Cotherapist

Goals: To Conceptualize and describe spatial individual family and processes, co-therapy

Group Issues: Re-group Building Subgrouping, self differentiation, control, blame

Family Issues: Crises, family as system, resolution, public and private

Therapy Issues: Differentiation - self in system, public and private

Session 10

Theme: The Self in the Therapist

Goal: Action techniques applicable to self and family systems

Group Issues: Sharing, Public-private, support and empathy projection: group members as family representatives

Family Issues: Individual perceptions composing the family field, feedback as new information

Session 11 and 12

Theme: The therapist and the alcoholic family

Goal: New ways of Intervening in Alcoholic Family

Group Issues: Sharing, public presentation of own work, competency, openness to new information, support

Family Issues: Use and abuse of alcohol, intimacy, control, fighting, violence

Therapy Issues: Different vantage points, techniques of intervening, therapist and family as system

Session 13

Theme: Co-therapy and the Alcoholic Family

Goal: New techniques of intervening in Alcoholic Family; New Ways of unfolding family system

Group Issues: Observe and conceptualize criticize flexibility to act when needed and role play with real family

Family Issues: Loss, extended family network, drinking as replacement for lost peer relationships, lost self-image

Session 14

Theme: Therapy of Alcoholic Family

Goal: What has trainee learned

Group Issues: Acceptance, support, public-private, flexibility to act with real family

Family Issues: Entry, control, loss, distancing, role of alcohol

Session 15

Theme: Review and Integration

Goal: Assessment - Discussion of transfer of learning to trainees work settings

Group Issues: Feedback: positives and negatives, saying goodbye?

Preference group formation and continuation

Family Issues: Letting go, maintaining contact and reunion.

Appendix B

OUTLINE FOR LECTURE SERIES

UCS ALCOHOLISM PROJECT

Feb. 3	Psychological and psychiatric theories of alcoholism.
Feb. 10	Sociological and cultural theories of alcoholism.
Feb. 17	Alcohol in the body and medical complications of alcoholism.
Mar. 2	Resources--A total mapping of programs for serving the alcoholic and his family.
Mar. 9	Alcoholism and the family.
Mar. 16	Emergency services and crisis intervention.
Mar. 23	Out-patient treatment.
Mar. 30	In-patient psychiatric programs.
April 6	Halfway houses for alcoholics.
April 13	Alcoholism and the skid row subculture.
April 27	Alcoholism programs in industry -- primary and secondary.
May 4	Teenage drinking and prevention.
May 11	Developing networks of services in an outline for a comprehensive alcoholism service plan.

Appendix B

March, 1973

THE BOSTON FAMILY INSTITUTE

UCS ALCOHOL TRAINING PROJECT

Session 1

Theme: Communication, Systems and Deviancy

Goals: Acquaintance, Group Building, Systems concepts, Deviancy Creating a context in which to learn.

Group Issues: Non-verbal messages, entry, membership, trust, play.

Family Issues: Steps of family formation, system interdependencies, degrees of deviancy and system coping processes, function of deviancy.

Session 2

Theme: Family Processes, Trust and sharing, Roles, Patterns and Development, Alcohol.

Goals: Group Building, Family Formation, Insights about Alcoholism as a family system phenomenon.

Group Issues: Membership, (in-out), roles, influence of Previous Experiences Together, Sharing and Trust

Family Issues: Various Family Styles, roles, decision making, choices, role playing, systems issues, patterns, leadership, alcohol as family issue.

Session 3

Theme: Personal Family Issues and Alcohol

Goals: Trainees Attitudes and experiences with alcohol and alcoholics and addictions.

Group Issues: Sharing, public and private issues, secrets, small versus large group issues.

Family Issues: Tolerance for any deviancy, early learning and early attitudes and feelings. Personal meaning of different addictions to trainees.

Appendix B

Session 4

Theme: Fighting, Intimacy and Blame with and without Alcohol and Intervention

Goals: Exploration of Fighting Styles, - "making-up" processes and therapy of family with alcoholic

Group Issues: Flexibility, role playing, control

Family Issues: Blame, control, and role of alcohol, alliances, intimacy and the systems which keep them going.

Therapy Issues: Observer roles assigned, co-therapy, boundaries; - in and out.

Session 5

David Kantor Presentation of Research in Families and Theory of Families.

Theme: Family, group issues - the family theory, your theory, treatment strategies. Devebpment of conceptual model and space, boundaries and bridges.

Exercise: Role play trainee's case.

Session 6

David Kantor - Entry and System Diagnosis - New Ways of Looking at and Dealing With Families Systems with Alcoholics.

Film: "The Summer We Moved to Elm Street"

Discussion: What would family be like in 10-15 years with small groups, intervention bases on hypotheses.

Session 7

Theme: The Therapist in the Self - Person and Therapist.

Goals: To conceptualize and describe spatially individual and family processes, co-therapy.

Group Issues: Re-group Building
Subgrouping, self differentiation, control, blame

Family Issues: Crises, family as system, resolution, public and private.

Therapy Issues: Differentiation - self in system, public and private. Therapists style of coping and respond

Session 8

Theme: The Self in the Therapist

Goal: Action techniques applicable to self and family systems.

Group Issues: Sharing, Public-private, support and empathy projection: group members as family representatives.

Family Issues: Individual perceptions composing the family field, feedback as new information.

Session 9

Theme: Therapeutic Strategies with the Alcoholic Family.

Goals: New Ways of intervening in Alcoholic Families.

Group Issues: Sharing, public presentation of own work, competency, openness to new information, support.

Family Issues: Use and abuse of alcohol, intimacy, control, fighting, violence

Therapy Issues: Difference in vantage points, techniques of intervening, therapist and family as system.

Session 10

Theme: Interventions with the Alcoholic Family

Goals: Deriving generalized tactics of therapy following the strategies.

Group Issues: Sharing therapy tasks, competency.

Family Issues: Alcoholism an family process - causing change.

Therapy Issues: What would you do if you didn't have this course? What do you do with present knowledge?

Session 11

Theme: Therapeutic transactions with Alcoholic Family

Goals: Specific techniques of therapeutic transactions.

Group Issues: Sharing Therapy tasks.

Family Issues: Alcoholism and family process - causing change.

Therapy issues: Specific techniques in sessions.

Session 12

Theme: Demographic facts, culture and prevention.

Goals: Integrating larger system and family systems issues.

Group Issues: Sharing with agency heads; presentation

Family Issues: The Alcoholic family within the society

Therapy Issues: Relating the broader issues to diagnosis and therapy

Presentation: Guests - Harold Demone, Ph.D.
Frederick Duhl, M.D.
Agency Heads

Session 13

Theme: Medical issues in treatment of Alcoholism.

Goals: Integrating physiological issues into a total approach to therapy.

Group Issues: Presentation and sharing of case material.

Family Issues: Responses to medical issues.

Therapy Issues: Integrating medical therapy with psychotherapeutic approaches.

Presentation: Guest - William Clark, M.D.

Session 14

Theme: Planning for therapy: Resources for Alcoholism.

Goals: Integrating community resources with family system therapy.

Group Issues: Presentation and sharing of case material.

Family Issues: The family, its use of community resources in dealing with alcoholism.

Therapy Issues: Approaching therapy as related to Alcoholism as well as family and personal dynamics.

Presentation: Guest - Edward Blacker, Ph.D.

Session 15

Theme: Interviewing of real family.

Goals: Observing therapist in action.

Group Issues: Family therapist models.

Family Issues: Live family presentation.

Therapy Issues: How to interview a family.

Presentation: Guests - Frederick J. Duhl, M.D.
Bernice S. Duhl

Session 16

Theme: Interview of real family.

Goals: Observing confrontation style of therapy and becoming an active therapist.

Group Issues: Social worker's identity as a family therapist.

Family Issues: Communication, focussing on Alcoholism.

Therapy Issues: Confrontation, Co-therapy, therapeutic intensity.

Presentation: Guest - Celia Delfano, M.S.W.

Session 17

Theme: Interviewing of real family.

Goals: Observing confrontation style of interview.

Group Issues: Therapist identity - uses of self in therapy.

Family Issues: The family's participation in Alcoholism.

Therapy Issues: Uses of the self, revelation and sharing, use of support and confrontation.

Presentation: Guest - Jack Donahue

Session 18

Theme: Review and Integration

Goals: Assessment - Discussion of transfer of learning to trainees work settings.

Group Issues: Feedback: positives and negatives, saying goodbye? Preference group formation and continuation.

Family Issues: Letting go, maintaining contact and reunion.

Exercises: Trainees discussed: What did I gain?
What I didn't gain but wished I had.

Session 19

Theme: Repeat of Session 18

Presentation: Agency Heads
Supervisors
Frederick J. Duhl, M. D.

Appendix B

BFI'S CONCEPTS AND CONCEPTUAL ASPECTS OF TRAINING

The seminar is concerned with treating its subject matter--the family, and, more specifically, the alcoholic and his family--as a whole, an entity in its own right, with unique properties understandable only in terms of the whole. This means a shift in emphasis from static structures and one-way causality to dynamics, process, and complex mutual interactions. On a general level, the features of concern center around the concepts of self-regulation or homeostasis. On a middle range level of conceptualization, concern centers around the concepts of social control, decision-making processes, communication and information exchange and the concepts of stress in relation to the organization and disorganization of human behavior: On a more empirical level, the seminar will attempt to illuminate how families of alcoholics function and maintain themselves as on-going systems.

Information will be considered that draws selectively from a wide range, including: (1) The family's general stylistic features--how it plays, what it laughs about, how members respond to trouble. (2) What their goals are--and whether they see themselves as moving up or down in the world. (3) How members express affection for one another--whether there is warmth, and who is loved and under what conditions. (4) How tasks are allocated--the way husband and wife perform conjugal roles, what tasks the children have and members contentment with their jobs. (5) How the family achieves its specific solidarity--whether the family is close and whether members consider its close and whether it is solidarity vis-a-vis the rest of society. (6) How dependence and independence is fostered--whether privacy is valued and how it is maintained. (7) How the family maintains ties--whether family and kinship ties are warm or strained, whether it develops warm ties with neighbors. (8) How authority and responsibility is worked out--whether role conceptions are "traditional" or "equalitarian", how discipline is carried out and how parents handle not only the aggressiveness of children, but their own aggressiveness and hostility toward the children and toward each other.

Each week the instructors work out in advance specific goals for the session, and suggested techniques and approaches for reaching the goals. Concepts are organized into four broad subject areas:

(1) Various models for looking at family and significant family processes.

Adaptations made by the non-drinking members to their own anger and frustration in their unsuccessful efforts to control the alcoholic's drinking.

Effects on the system and its members when the drinking member fails in his formal role responsibilities: for example, when a mother becomes the breadwinner and makes major decisions for the family that are ordinarily handled by her husband, or when a child is forced to take on tasks ordinarily performed by parents.

Particular subsystem effects when the total system is in a state of disequilibrium: for example, when the drinking member absorbs the bulk of the family's psychic energies, or otherwise disrupts the flow of affect and affection, the children may be left emotionally deprived.

The problems of therapeutic strategy brought forth by the kinds of systemic effects cited above: for example, questions about the size of the family unit to be brought into the therapy. Since children are subject to confusion about authority, discipline, identity, and sexuality, can there be family therapy which fails to include them in these significant family processes?

Effects on the system occasioned by the family therapist and his interventions: for example, a wife's inability to shift back into normative role behaviors when her husband stops drinking.

As suggested above, the family is viewed as a complex adaptive system which consists of components which are themselves complex and which, in their interrelatedness, take on certain of their more important properties by virtue of being parts of the larger whole. The importance of this view of the dynamic interrelatedness of component parts is especially evident when dealing with an identified "alcoholic" whose characteristic performance makes emphatic the necessity for the joint study of parts and the larger whole--including the physiological, psychological and social and sociocultural components--with full appreciation of their reciprocal determination. The Lecture Series teaches about these component parts. The Seminar Series, through its concern with the notion of system; teaches about the dynamic interrelatedness of these components, and how to go about trying to change them when they are not functioning properly.

(2) Various models for changing families and methods and techniques of family intervention.

(3) The nature and etiology of alcoholism.

(4) Treatment of the Alcoholic and his family.

In looking at the family as a disturbed system, the following broad questions serve as a guide:

(1) What patterns of family interaction and what aspects of family structure appear to be related to the development of health and disturbance (alcoholism)?

(2) What is responsible for the maintenance of the disturbance?
Specifically:

(a) What individual functions are served?
(b) What family functions are served?
(c) How do motivational, psychological, and interpersonal factors interact with family factors to help maintain disturbance?

(3) What is the relationship between observed family interpersonal patterns and the pathology of the primary patient?

(4) How do families from different social and cultural backgrounds vary in structures and processes which they develop in relation to disturbance?

(5) How do families with an identified alcoholic member differ in their organization and interaction patterns from families with no known members and from families with non-alcoholic pathology?

(6) What implications does the approach proposed here have for the therapeutic intervention?

Some of the more specific substantive issues that center around the stress on the family system that is created by one member's excessive drinking behavior, include: